the **JOURNAL** *of* **SOCIAL THERAPY**

Official Publication of the Medical Correctional Association

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disseminates information on the genesis, nature and treatment of aggressive behavior. It aims to encourage enlightenment through wider employment of the scientific approach. The benefits that can be drawn from this growing body of knowledge spring from its practical application with these objects: To reduce behavior that is destructive to the individual; and to minimize the costly and demoralizing impact upon society of all forms of deviant conduct.

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POINT OF VIEW

Will-o'-the-Wisp: A Therapy for Alcoholism

IN mental illness and alcoholism, social therapy bears responsibility for two of the four major health problems of the world, the others being cancer and heart disease. Recent progress in the amelioration of mental difficulty and in control of heart trouble are among the historic advances of our time; but alcoholism, like cancer, remains a challenging enigma as well as a ravaging calamity. Further clarification of the psychic, and perhaps physical, deficit that drives men and women to self-destruction through drink is therefore one of the two leading avenues in which research can be stimulated with most profit.

Applied effort is not wanting. Federal and state budget grants for expanded study of the problem signify public recognition of this need. The National Institute of Mental Health, the National Council on Alcoholism and the Yale University Center of Alcohol Studies, among other institutions, are pressing the quest for still elusive basic discoveries. Notable strides have been made in the elucidation of the so-called alcoholic personality and the complexity of vectors that underlie the habit. Yet the prevention and certain relief of pathological drinking remain in the realm of unfinished projects.

As Dr. Marvin A. Block has said: "There is no miracle drug that can do away with the illness . . . no constant symptomatology, no

specific treatment, no foolproof method of picking out victims in advance. An alcoholic's proneness to the disease is a secret between him and the bottle."

Psychiatry can find food for humility in the fact that Alcoholics Anonymous has won recognition for achieving the most effective current results in managing problem drinkers. Yet this social-group technique is but a simplified and adaptive form of group psychotherapy, which also is efficacious in helping alcoholics to palliate their difficulty. Full-scale individual psychotherapy also has proved feasible in some cases, though usually undertaken with frank misgivings in view of the drinker's signal unamenability to patient, long-term exploration. Even where the alcoholic can be persuaded to stop drinking, the persistence of his underlying personality deficit demonstrates the truism that indulgence is a symptom rather than the root of the disease.

This elusive complexity of the basic pathology also explains the finding that alcoholism is seldom a cause of crime but rather a contributing factor. This is especially true in cases where the alcohol serves to trigger an underlying disorder. In one recent case a young man who parked his car with a girl after heavy drinking awoke from his stupor to discover that he had murdered her. Clinical examination revealed that the man was subject to epilepsy, which evidently had been brought into play in his drunken state. The court eventually accepted the medical findings in support of a plea of criminal irresponsibility. In many cases there is strong evidence that alcohol contributes to violence or other offenses by acting upon pathological defects that may ordinarily remain dormant or undiscovered.

Cumulative experience with and observation of alcoholics testify to the labyrinthine complex of drives, frustrations, paradoxes and ambiguities that marks the personality so afflicted. Infantile oral patterns, displacement of love object, diffraction of ungratified eroticism, elements of homosexuality, sense of guilt with its need for punishment, aggressiveness masking inferiority feelings and inchoate thwartings, gropings for fortification of obscure deficiencies — these and many other constituents in phantasmagorical combinations are commonplace in the sufferer. Dr. John D. Armstrong of the Alcoholism Research Foundation of Ontario illustrates in an article in this issue how trying and exasperating these coruscations can become for those who must associate or deal with the alcoholic. Yet it is all too evident as well

that these people are often talented and useful in other ways and even proverbially endearing in social contacts. The endeavor to salvage them and to prevent others from becoming like them, therefore, looms as an eminently worthwhile task beset by intricate difficulties.

The overriding aim of the study of alcoholism remains, of course, the continued quest for a physical explanation of the conditions that cause susceptibility to addiction, with the possibility of finding pharmaceutical or other therapeutic means of allaying and preventing it. By means of persistent research — statistical, physiological, pharmaceutical, sociological and psychological — the secret should not be unattainable. Meanwhile, the widening of available facilities for individual, family and community therapy, together with educational efforts focused on prevention, can go far toward reducing the deplorable havoc of alcoholism's scourge.

The No Man's Land of Chemotherapy

ONLY a few years ago the notion that man would some day do much of his work by pressing buttons and would maintain his physical and emotional wellbeing by taking certain pills was regarded as a fanciful dream realizable, if at all, in the distant future. Today we casually accept the automation of industrial, commercial, scientific and household tasks as commonplace and confidently await the evolution of further cybernetic miracles. In the realm of chemotherapy we have quickly become accustomed not only to the prevention and alleviation of dreaded maladies by simple pharmaceutical means but also to the regulation and treatment of mental illness by specific drugs. Lest we surrender to too complacent a mood of self-congratulation, however, it is timely to ask whether the boon of rapid scientific progress is attaining its full range of potential usefulness.

One conspicuous omission in the application of the spreading benefits of chemotherapy is to be found in the neglect, so far, of its obvious possibilities in the field of correction. There is hardly an area of pathology where the new techniques of prescription could be applied more aptly and demonstratively than in the prisons. Yet one

looks in vain for evidence that the opportunity has been recognized on any considerable scale.

Modern correctional practice acknowledges that most prison inmates are essentially disturbed people. Many of them are in difficulty through faulty administration of those natural forces that, when properly balanced, constitute the normal life of the nonoffender. The view that they are often victims of a remediable pathology is the very essence of the therapeutic aim. There is no doubt that, by allaying the aberrant elements and bringing the healthy factors of personality into focus, great numbers of these people could be helped back into a useful way of life. Chemotherapy offers a signal means of starting and facilitating such a transformation.

Even as a simply humane device, the routine administration of tranquilizers not only would moderate the ordeal of imprisonment but would help to simplify control and administration. Few men go to prison complaisantly; typically they are seething with protest, rancor and rebellion. Their loss of liberty, public degradation, divorcement from normal contacts, sexual deprivation and herded regimentation rankle in them as catalysts of reactions least favorable to any idea of reform. If this condition of tension and agitation were reduced, the inmate would be better able to adjust to his situation and would be more amenable both to discipline and to therapy.

The state hospitals' experience with chemotherapy offers a striking demonstration of its virtues: caseloads reduced, relapse rates cut, administration and therapy eased despite personnel shortages. Here an obvious parallel with the prison problem suggests itself. If correctional endeavor is to achieve its promise, it must be directed more and more into therapeutic channels for the benefit of prisoners found treatable. At least some correctional institutions can and should be operated much in the manner of mental hospitals, treating their patients as sick people rather than as offenders.

Another logical but neglected objective of correction could be served by chemotherapy: the interests of scientific research. As part of the concept that prisons, or their equivalent, should be useful organisms, rather than sterile limbos, their therapeutic endeavors should contribute to the sum of practical knowledge. Without making prisoners laboratory subjects, data based upon their response to therapeutic techniques could be collected and coordinated for the

advancement of our understanding of man in all aspects of health and pathology. Chemotherapy in prisons could become an invaluable avenue to that end.

That minor problems in the administration of pharmacal agents in prisons might arise is conceivable, but they need not be an insuperable obstacle. With the judicious classification and separation of prisoners that is now too little practiced, chemotherapy could become a means of revolutionary benefit to the offenders themselves and of incalculable long-range profit to society.

Clarifying the Definition of Insanity

THE present statutes here and in many other states stem from a concept of "insanity" that has long since been by-passed in the advances of scientific research. That research is far from complete but it is already so compelling in its weight of evidence as to make us revise quite a lot of our thinking about the aberrations of the human mind.

"And at long last, to our credit, we are beginning to understand that these various deviations from what we consider a norm of social behavior must in many cases be analyzed and handled in exactly the same way that we treat deviations from the norm of expected health. We are finally beginning to realize that when we say 'insane' what we really mean is 'mentally ill'."

This passage from an editorial in *The New York Times* should have a familiar ring for long-time readers of this *Journal*. It expresses the theme and spirit of countless articles and discussions that have appeared in these pages through the years. That the viewpoint of an enlightened public has "at long last" confirmed this basic tenet of social therapy gives occasion for gratification for the progress of general opinion and for the triumph of the aims of social science.

The topic under discussion was, of course, the old debate over what is to be done to reduce the forensic obstacle of the hoary McNaghten Rule. An epochal turn in the struggle with this quandary was reached when the New York State Bar Association endorsed a

new legal definition of insanity that would open the way for a more sensible and realistic disposal of cases in which the criminal responsibility of an offender is plainly open to question. Acting on the recommendation of a committee of inquiry appointed by the Governor, the Bar Association proposed to adopt the language of the model penal code of the American Law Institute. This would recognize the irresponsibility of a defendant if at the time of the crime, "as a result of mental disease or defect, he lacked substantial capacity to know or to appreciate the wrongfulness of his conduct or to conform his conduct to the requirements of law."

Thus the perennial stalemate between rigidly literal legal concepts and the possibilities of constructively reasonable psychiatric counsel shows signs of abating. The dilemma will not be solved magically by an agreed definition of terms, for other vexing aspects of the problem remain to be worked out. But this manifestation of eagerness on the part of a considerable body of legal opinion to see procedure clarified is perhaps the most encouraging development to date in the long, stubborn and frustrating controversy. With goodwill and amenability on both sides, dictated by recognition of the basic elements of enlightened justice, the answer that has eluded the best efforts in both camps should not be lacking much longer.

Psychiatrists, it is hoped, may now look forward to a time when they will no longer be used as humiliated pawns of opposing counsel, but will take their proper dignified place as friends of the court, to be heeded in objectively determining questions of health or illness, without becoming involved in such nonmedical considerations as malice, right and wrong or criminal intent.

At any rate, the prospect that New York State courts will soon join the Federal and other state jurisdictions in jettisoning the McNaghten Rule is a matter of high encouragement and some jubilation.

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A FURTHER STUDY ON THE EFFECT OF MEPROBAMATE ON ANXIETY REACTIONS IN PENITENTIARY INMATES*

Harry Brick, M.D.

W. H. Doub, Jr., M.A.

W. C. Perdue, B.S.

ENCOURAGING results were obtained when troublesome inmates, kept in "special confinement," were treated with meprobamate.[1] This favorable response led us to investigate the general use of the drug on a group of prisoners who had displayed anxiety and tension. For this study, we used a new prolonged-release form of meprobamate (Meprospan), chosen for its sustained effect and simplicity of administration.

METHODS

1. *Selection of Subjects*

All the prisoners selected were those who had shown signs of anxiety and tension. There was no evidence of mental retardation or physical disease in these men. They were willing to cooperate, were personally known to the staff and each had been interviewed by two of the investigators prior to the start of the experiment. Most of the subjects had previously received other treatment and all volunteered for the study.

*This project was carried out with the full cooperation of Major W. Frank Smyth, Jr., Superintendent, Virginia State Penitentiary. The Meprospan was supplied by Wallace Laboratories, New Brunswick, N. J.

These men were divided into two groups, using a method of randomization based on their prison serial numbers. Those having an even number as the last digit were placed in a control group (26 men), while those with an odd number as the last digit were assigned to the experimental group (33 men).

2. *Treatment of Subjects*

Placebos were given to the control group; the drug, Meprospan, was administered to the experimental group in the form of two 200 mg. capsules each day for eight weeks, a dosage considerably smaller than the recommended 800 to 1600 mg. of meprobamate per day. The ends of the capsules were colored green (placebos) and yellow (Meprospan); except for the colored half, they were identical in form and appearance. In order to obtain objective results, a double-blind technique was used and the capsules, all identical in form and appearance, except for the colored half, were given individually under observation. The contents of the capsules were not known to the prisoners or to the person administering them.

3. *Testing of Subjects*

Results obtained from the Rorschach Test[2], [3] are in numerical form and are not easily influenced by the patient. This technique, which we used in our previous study of meprobamate, was again employed to assess the subject's condition and to obtain statistical evidence of the effect of medication.

Harrower-Erickson[4] found certain score patterns especially frequent in neurotics and infrequent among comparable normals. He listed *nine Rorschach signs of neurosis* with the assertion that any subject showing five or more is likely to be neurotic and possess strong anxiety traits. The traits are listed below with the comparison of normal traits as listed by Piatrowski and others[5], [6].

Neurotic	*Normal*
1. 25 or fewer scorable responses.	1. 25 to 50 responses.
2. Not more than one human movement response.	2. 2 to 5 human movement responses.
3. Greater animal movement than human movement responses.	3. More human movements than animal movement.

Neurotic	*Normal*
4. Evidence of color shock.	4. No color shock.
5. Evidence of shading shock.	5. No shading shock.
6. Rejections (refusals to respond).	6. No rejections.
7. Over 50% form responses.	7. 25 to 50% form responses.
8. Over 50% animal and animal detail responses.	8. 25 to 50% animal and animal detail responses.
9. Not over one form controlled color response.	9. 2 to 5 form controlled color responses.

The nine Rorschach signs of neurosis were tested on every subject before the drug was given and at the end of the experiment. Comparison of the number of neurotic traits exhibited by individuals of the two groups thus provided an evaluation of the effect of the drug.

RESULTS

BEFORE medication, 151 neurotic traits were recorded for the 33 patients comprising the treated group. After medication, this number was reduced by 30% to 105 traits. In the control group, consisting of 26 men, 130 neurotic traits were noted at the beginning and 123 traits at the end of the experiment, a reduction of 5%.

Figure I shows the average number of neurotic traits per patient in each group. In the treated group, the average was 4.6 prior to medication and 3.2 afterward; in the control group, the corresponding figures were 5.0 and 4.7. The reductions in numbers of traits, 1.4 and 0.3 per man respectively, are significantly different. Forty-two per cent of each group scored from five to nine neurotic traits, and improvement due to the drug was even more marked in these severe cases. Here, the average reductions in numbers of traits were 2.3 and 0.4 respectively.

In Figures II and III and Table I, the nine neurotic factors are considered individually. In the treated group, the results for six of the factors were considerably better at the end of the experiment, for another factor there was slight improvement, and for two there was no change. In contrast with Meprospan, placebos effected only minor changes, except in responses to color shock. The six factors most af-

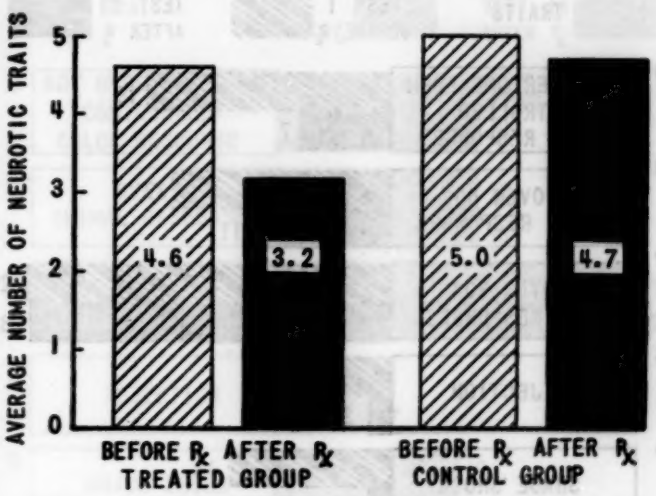


FIG. 1. A COMPARISON OF AVERAGE NEUROTIC TRAITS FOUND ON THE RORSCHACH TEST BEFORE AND AFTER MEDICATION

fected by medication were: (a) form controlled color response; (b) animal responses; (c) rejection; (d) shade shock; (e) color shock; and (f) animal movements greater than human. Form percentage responses showed slight improvement in the Meprospan group. These quantitative results indicate the quality of changes occuring in the patients. For instance, in the six factors (a-f) affected by Meprospan:

(a) increase in form controlled color response reflects increase of emotional control.

(b) decrease in animal responses relates to increase of intellectual adaptivity and social maturity. A result of over 50% is a definite sign of anxiety.

(c) decrease in card rejection indicates an increase in emotional stability. In the treated group, rejection decreased by 68% and in the control group by only 25%.

(d, e) decrease in the number of both shading and color responses is correlated with decrease in anxiety. Shading responses in

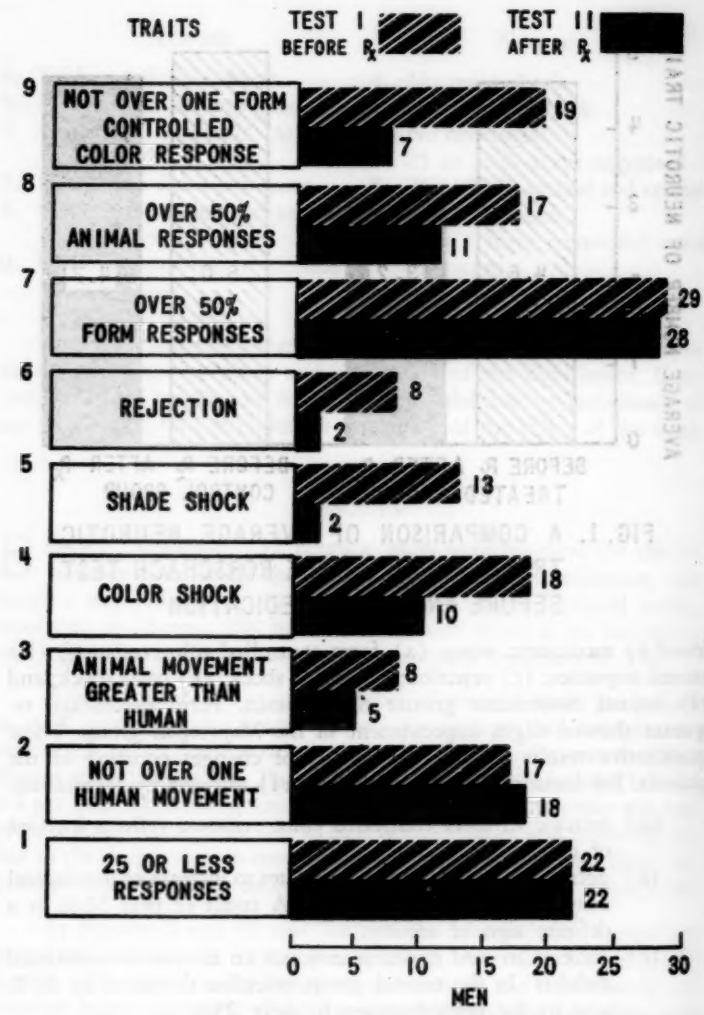


FIG. 2. RORSCHACH SIGNS OF NEUROSES AS FOUND BY HARROWER-ERICKSON: CHANGES IN THE TREATED GROUP

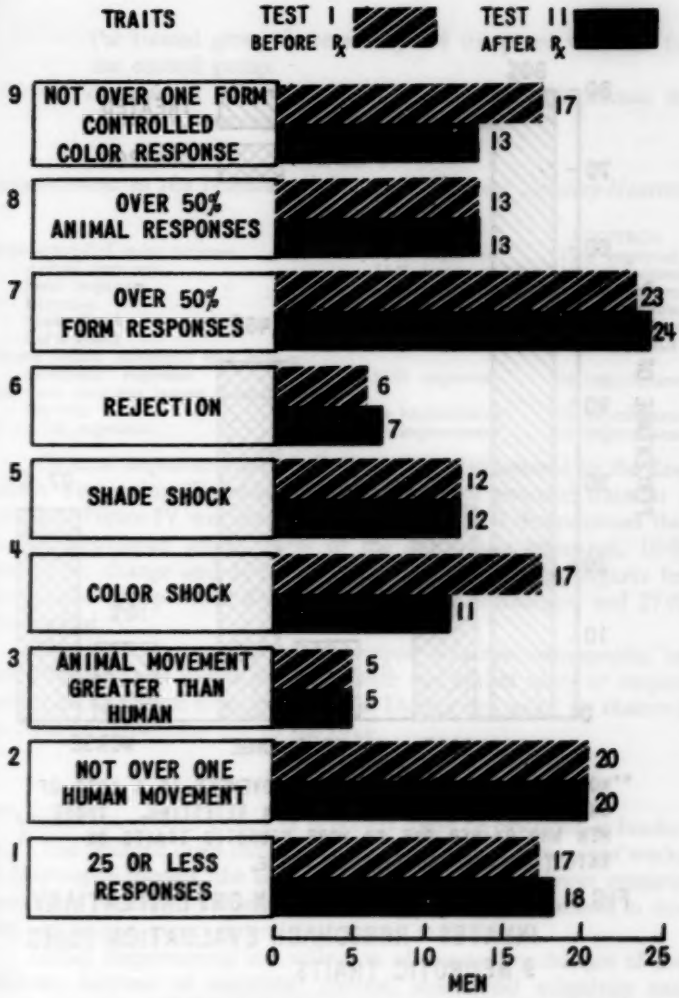
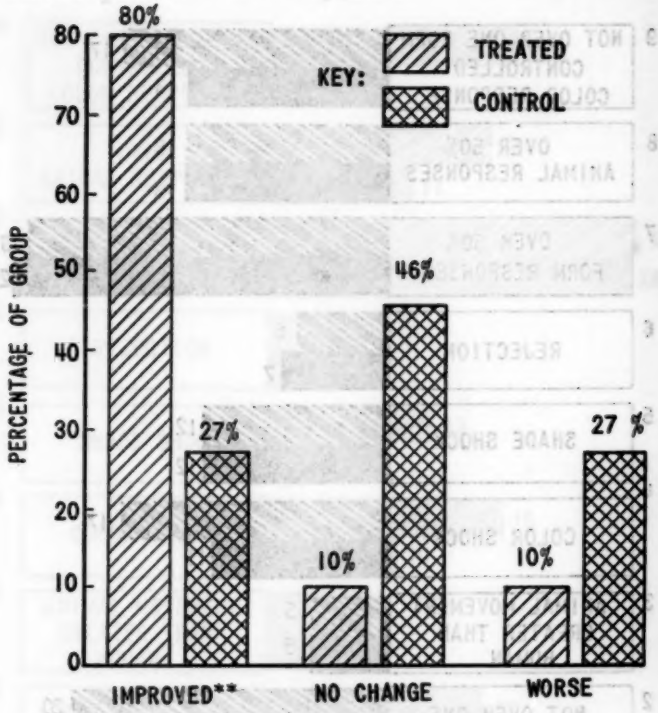


FIG. 3. RORSCHACH SIGNS OF NEUROSES AS FOUND BY HARROWER-ERICKSON: CHANGES IN THE CONTROL GROUP



**NOTE: THE CRITERION FOR IMPROVEMENT IS A LOSS OF ONE OR MORE NEUROTIC TRAITS ON RETESTING. THOSE MEN WHO GAINED ONE OR MORE NEUROTIC TRAITS ON RETESTING WERE CONSIDERED WORSE.

FIG. 4. EFFECTS OF MEPROSPAN ON PENITENTIARY INMATES - RORSCHACH EVALUATION USING 9 NEUROTIC TRAITS

the treated group decreased by 2.4 compared with 1.7 for the control group.

(f) decrease in animal movements compared with human indicates a lessening of personality conflicts.

TABLE I

Improvement in the Number of Prisoners Showing Anxiety-Neurotic Responses

	TREATED	CONTROL
Form controlled color response	63% improved	23% improved
Animal responses	35% improved	No improvement
Form responses	3% improved	No improvement
Rejection	75% improved	No improvement
Shade Shock	85% improved	No improvement
Color Shock	44% improved	35% improved
Greater animal movement than human movement responses	38% improved	No improvement
Not more than one human movement response	No improvement	No improvement
25 or less responses	No improvement	No improvement

General improvement of individuals was also assessed by the Rorschach Test, using the reduction in numbers of neurotic traits as a criterion. Figure IV was constructed on this basis. It demonstrates that in the Meprospan group, 80% of the individuals improved, 10% showed no change and 10% deteriorated. Corresponding figures for the placebo group were: 27% improved, 46% unchanged and 27% deteriorated.

The improvement due to Meprospan was not accompanied by any ill-effects, and this is in accord with our earlier study of meprobamate using a three times greater dose. During our study, we observed no signs of drowsiness due to the drug.

DISCUSSION

ORIGINALLY, both groups of prisoners could be described as borderline neurotic cases showing anxiety tendencies. After eight weeks of Meprospan therapy, the treated group improved and fewer neurotic traits were present. If all prisoners showing anxiety were treated in this way, we might expect fewer disciplinary problems.

Group improvement is a reflection of personality changes of the subjects: increase of emotional control, intellectual adaptivity and social maturity, and decrease of anxiety and conflict. Modifications of this type are particularly desirable when maladjusted individuals have to live closely together.

The evidence already given shows that any one prisoner suffering from anxiety and tension has a four to one chance of an improved mental condition from treatment with meprobamate. There is also supportive evidence of smaller, positive effects which are not revealed in the numerical results. An increase in dosage above the 400 mg. per day used in this experiment would probably have made these effects more pronounced, since they are similar to the greater effects obtained with 1200 mg. per day of meprobamate in our first study.

In conclusion, we believe that medication of the type described in this work will do much toward removing the less desirable psychological effects of prison life and preparing the way for future rehabilitation.

SUMMARY

A double-blind study of 59 prison inmates was carried out under controlled conditions to test the effectiveness of Meprospan (a sustained-release form of meprobamate) in reducing tension and anxiety. The Rorschach Test was administered before and after an eight week course of medication. Nine Rorschach signs of neurosis were used for evaluation of the effectiveness of the medication. Used in very small dosage (400 mg. per day), the drug produced a positive result — improvement in 80% of the treated cases as opposed to 27% of the control cases (which received a placebo under the same conditions). The patients who were most seriously disturbed showed a greater degree of improvement than the treated group as a whole. No adverse effects or allergic reactions were noted and no indication of addiction appeared. It was concluded that the drug, even in half the recommended dosage, does reduce the anxiety and tension to a significant degree in a substantial number of these men and that further study and use with increased dosage seems indicated.

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ALCOHOLISM—A SOCIAL DILEMMA

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ALMOST daily the word "alcohol" appears in some of our newspapers, in accounts of motor accidents, assaults, murder or other tragedy. The case books of doctors, social workers, clergymen and lawyers contain this word over and over again in reference to disease, destruction or other social disturbance. It may still surprise some to know that in a high percentage of these cases we are not just dealing with a man who had one too many and who was unfortunate enough to have an accident or an injury under the influence of alcohol. All too often these people have been known as heavy drinkers; known to their families, known to their employers, known to their doctors or to the courts. They were known to depend on alcohol for many years, dependent to such a degree that their personalities had changed, their attitudes to those around them altered, their behavior increasingly irresponsible. They were unreliable, irritable, difficult, resistant. They were physically, mentally and often morally deteriorated. It was almost inevitable that eventually there would be the tragedy which brings them to our attention.

Popham[1] has recently reported examining the motor accident

records of a large metropolitan area in which alcohol was involved. The number of drivers involved in these accidents who had also been known as patients in one of three local clinics was greater than would be expected if each group were represented proportionately throughout the city population.

Perhaps, if this were really an inevitable and incurable state of affairs, we would accept it, but such is not the case. The alcoholic can be rehabilitated, and we believe the disease, alcoholism, can be prevented. This is not a new problem. Man, with his peculiar kind of ingenuity, probably discovered the use of alcoholic beverages before he knew how to read or write. Certainly, the written records we have indicate that this beverage has been known for a long time. It has been giving pleasure and entertainment and has been part of man's life up to our present time.

The use of some form of alcoholic beverage is found throughout the earth as part of innumerable cultural groups, particularly in those areas which we think of as Western culture. Alcohol plays a part sometimes in the most solemn, or conversely, the most exciting rituals of man's religions. It may be a normal accompaniment of his meals. It may play a part in his celebrations. It may be thought of by the physician as an appetite stimulant, a reliever of pain, an elevator of depressions, a dilator of blood vessels. To others the meaning is more obscure but frequently of greater importance—alcohol dulls awareness of day-to-day pressures of boredom, permits escape to realms of phantasy, removes various inhibiting barriers permitting behavior which would not occur otherwise.

It is from this latter group that we generally draw those whose use of alcohol becomes sooner or later a problem to themselves or those about them.

In the Harveian Oration of the Royal College of Physicians, London, in 1955[2], Sir John Charles makes reference to concern of members of the College at the growing excessive use of alcoholic beverages, particularly gin, among the people of London over two hundred years ago. Gin was described as being "the solace of the henpecked husband, the kind companion of the neglected wife, the infuser of courage into the army, and the support of the pawnbroker." As a result of its concern, representations were made by the College to Parliament in 1826. These,

combined with the demands of other public officials, eventually brought about legislation that sufficiently controlled the sale of beverages to lessen the problem noticeably in London.

When one reads such a report one suspects that the problem may not be so widespread now as it was then, but the delightful descriptions of the uses of alcohol are as apt today as they ever were.

A method of estimation has been devised by Jellinek for determining the number of alcoholics in a given population.[3] Where accurate checks have been possible, it has been found that the Jellinek formula produces results that are quite comparable.[4] Using the formula for known census figures and by calculating for known rates of increase in population, it was suggested that by the beginning of 1957 there would be 180,000 alcoholics in Canada. By similar calculations one would expect to find millions of sufferers from this problem in the United States.

These figures would be alarming enough if we knew that all cases were being detected and receiving treatment and that maximum improvement would be achieved, but we have also reason to believe that only a small percentage, perhaps 10% of the alcoholics in any community, have ever been under any kind of treatment, whether in a clinic, through their own doctor or through Alcoholics Anonymous, without regard to the degree of benefit they received from that treatment. It is true that we have no magic formula for treatment of this disease, but the results we do get with patients who come to us and remain with us are most encouraging. Each year adds a considerable number to the list of alcoholics who have been treated by various special clinics, by their own doctors or by Alcoholics Anonymous. Unfortunately, it isn't simply a matter of identifying the cases and sending them to treatment. Many of these people are certainly recognized as problems of one sort or another by those around them, and many of them are truly identified as alcoholics. The problem of encouraging the alcoholic to come to treatment demands that we look for a moment at the disease itself. Most of us are familiar with the well developed alcoholic. We have heard his excuses—"A few drinks never hurt anybody." "I do my work better." "What I drink is my own business." We recognize him so well that we make stories and jokes, which we enjoy immensely, based on his incapacity to perceive his surroundings and to make errors in judgment in a way that is different

from the way the rest of us do. However, when we take his alcohol away we often find that there is still something a bit unusual about this person.

At this time I do not think it profitable to argue whether alcoholism is merely a symptom of an underlying psychological disorder or whether it is a disease in its own right. It is certain sure that sufficient alcoholic patients have neuroses, character disturbances or other evidence of psychological disorder that this must be an important factor in considering treatment. On the other hand, let us not dismiss too readily the concept of alcoholism itself as a disease, or if you prefer it, a syndrome. Certainly there are patterns characteristic of prolonged dependency on alcohol that are more complex than the mere fact that increasing amounts of alcohol are being used to relieve the symptoms of other disorders. The nature of this syndrome or symptom complex may differ in character from our common conceptions of disease, but this should not discourage us from looking at alcoholism as a medical entity, even though we must seek further to define it precisely. Unfortunately, not only are there complex patterns of disease drinking and complex underlying disorders that make the drinking feasible, but there are many social customs related to the use of alcohol that influence the way in which the substance is used by the individual and thus also influence to some extent the rate and degree to which the person becomes dependent, and possibly the kind of defenses he will establish in retaining his use of the drug.

While one must agree that there is no proof to date of a specific personality that can be labeled as alcoholic[5], one suspects that certain constellations of personality characteristics may be found more consistently than others in the alcoholic population[6]. At the same time, it is not always reasonable to assume that these characteristics are entirely the result of or are uniquely associated with drinking behavior. Frequently one observes that certain elements of behavior are common not only to the way a man drinks, but in the way he drives his car, in the way he responds to business commitments and in his attitudes to his family and his associates.

Gliedman[7] has recently drawn our attention again to a deficit in time sense found frequently among alcoholics as well as other personality disturbances. Characteristically these patients seem suspended

always in an expansion of the present moment of time; they are linked only tenuously to their past history, with poorly related islands of memory, and have little capacity to envision the likely future based on their past experiences. This may be our fundamental problem in maintaining the certainty of treatment we believe necessary for the alcoholic's recovery. An alcoholic has difficulty learning from the past, or even recalling and reporting it in a systematic way. As a result, the alcoholic is considered unreliable, exaggerative, prevaricative and inconsistent, when in fact he has no recallable basis on which to establish the facts he wishes to communicate.

Thus we must recognize that in the alcoholic individual, drunk or sober, we are frequently dealing with a person showing difficulties in perception of his surroundings, in sensitivity to the meaning of what is perceived, in forming judgment as to a course or in remaining consistent in the following of a course planned.

Now, in many instances, we look on these sick people as relatively harmless. They are amusing when we see them at a party and they enjoy amusing us. They may be inefficient on their jobs; we may feel sorry for their wives. We forget that some of them are menaces. They are the people who assert that they can drive as well when they've been drinking as when they are perfectly sober. They are the people who think it is perfectly safe to smoke in bed. They are the people who think it is quite justified to hit someone with all their might when they are thwarted. They don't necessarily intend to be destructive; they are unable to appreciate what they are doing at these times. Alcohol removes the control from destructive impulses that are normally curbed.

Now, this is the group of people we must try to reach. These are the people who have a disease that is causing them to create considerable damage and destruction in their community. They are not aware of the extent of its duration or they are accepting it as their lot. It seems preferable to a life without alcohol. They do not respond to logic and obvious approaches to help them. These are unfriendly gestures and regarded with suspicion.

Thus we treat only a small percentage who come voluntarily before a great deal of needless pain and suffering occurs to themselves and others. Some others, coming under various kinds of pressure, can be helped — by using an accepting, relatively impersonal and non-

threatening approach—to accept some understanding of their illness.

But what of the others? When other diseases result in the infliction of pain and suffering to people, we have found means of controlling them. We have regarded these diseases as problems in public health. It has been suggested that alcoholism is our largest unsolved public health problem. In terms of other illnesses, alcoholism now exists in our communities to an extent greater than tuberculosis, venereal disease, poliomyeltiis and many others added together, and new cases are springing up far out of proportion to the numbers being controlled. Now, recently, when it has been suggested in Ontario that we might investigate the possibility of exerting some legal control over the alcoholic,[8] it has been asserted that a man should have the right to decide for himself if he will drink himself to death. However, we do not give men this right with regard to other means of self-destruction. We may not shoot ourselves or drown ourselves. We may not even starve ourselves to death. It is usually presumed that when we try to do these things we are suffering from some mental disturbance, and we can be sent to a hospital until we are better. If a man is addicted to the use of narcotic drugs instead of alcohol, we will throw him in prison for merely possessing the drug which makes him ill, and yet, in the United States prior to 1914, it was estimated that there were at least a hundred thousand, and some would say a million, people addicted to narcotics.[9] These could be bought in the drug store without a prescription and, mixed with alcohol, they provided the basis for many a patent medicine. In fact, they were frequently found in soft drinks, since they would induce the drinker to buy more of the product. Now we tend to think of alcohol today as something different from the narcotic drugs, but we have obviously changed our thinking about the narcotics. Should we be examining more carefully our attitudes to the use of alcohol? It is true that narcotic drugs enjoyed only a relatively short life of popularity compared to the long history of alcohol. It is true that addiction to narcotic drugs is easier to establish. But it is a moot point as to which is the more serious disease for an individual. Certainly alcohol, like the narcotics, is a drug, and its pleasure and pain are due to its interference with brain and nervous system activity.

As a matter of fact, we should not find the idea of insisting on the alcoholic's getting treatment so unusual. We already have means of committing the alcoholic to an Ontario mental hospital,[10] but most

families are willing to do this only as a last resort when they can no longer continue to be exposed to the behavior of a particular individual, feeling that this does not meet the needs of the patient's illness. Surely it is not unreasonable to suggest that we explore the possibility of coping with this problem long before the individual reaches the final desperate stages or before there is a serious accident, death or permanent mental deterioration.

One special example of the alcoholic who is resistant is the patient who is drunk and fighting when the doctor arrives. Something is indicated for protection of family and patient, but the family is reasonably hesitant about calling in the police. Some plan of medical observation ward might be indicated, to which a person could be taken for a brief period until the extent of his problem could be established and an adequate disposal recommended.

In other countries, attempts have been made, and are being made, to face this problem. Apart from dealing with the question of alcoholism specifically, in England the hospital system provides for the apprehension and for observation of various kinds of mentally disturbed individuals, including the alcoholic, for such time as can permit an assessment of his mental state to be done. Switzerland and Holland, in particular, have established legislation that permits the examination of an individual and some decision as to whether he is capable of managing his own affairs or must be maintained in some kind of supervision. Legislation permits the control by some judicial agency of the person's activities and at the same time gives a relatively free hand to treatment organizations that may manage the individual on either an out-patient or an in-patient basis. In the District of Columbia[11] certain recommendations were recently made by a subcommittee of the American Bar Association. These recommendations are:

1. Alcoholics who are charged with the offense of intoxication should be treated as sick individuals and not as criminals.
2. A Commission on Alcoholism, similar to the Commission on Mental Health, be established, which would be responsible for holding hearings in the case of chronic offenders and making recommendations for commitment and treatment.
3. Penal statutes that set fines and imprisonment for the offense of intoxication be repealed.

4. Legislation be proposed permitting commitment of alcoholics for treatment for an indeterminate length of time.
5. A hospital ward for screening alleged alcoholics, and a convalescent home or day hospital with a controlled therapeutic environment, be established; an institution for the long-term treatment and custodial care of chronic and deteriorated cases where other treatment has not been helpful.

In a personal communication, Dr. Anthony Zappala, Chief of the Alcoholic Rehabilitation Division of the District of Columbia, states, "I am convinced that a rehabilitation center with a therapeutic community atmosphere should receive many of the chronic repeaters that frequent our courts. I further believe that an indefinite stay must be recommended."

In Ontario at our own clinic we have had examples, in an informal way, of

1. A county court judge's withholding recommendation for commitment to an Ontario Hospital pending a trial of treatment under the facilities of Brookside Clinic;
2. A magistrate's suspending sentence pending trial of treatment at Brookside Clinic.

We are of the opinion that, while examples of this kind of pressure have been relatively infrequent, the results obtained have been comparable to those that obtain when other kinds of pressures are used to bring a man to treatment, e.g., threat of loss of employment or loss of domestic accord or, in fact, in those cases when it is assumed that the patient is well motivated because the threat of loss is something that he recognizes as being implicit in his presenting problem rather than having been necessarily made explicit by a court, an employer or a wife.

It seems obvious that the ultimate goal in dealing with alcoholism will lie in the realm of prevention, and the assumption possibly can be made that such prevention will be related in some way to changes in attitude and social custom, since differences in social and cultural behavior now seem related to the incidence of alcohol problems in certain groups in the community. The scope of this paper is not necessarily to deal with prevention, but to look at the problem facing those attempting to deal with existing disease.

As suggested above, a certain measure of success can be achieved once the patient comes to treatment, and those concerned will continue to improve ways of using medication, nutritional supplement, individual and group psychotherapy, physiotherapy, recreational therapy. A modern clinic team includes physicians, psychiatrists, social workers, nurses, psychologists, physiotherapists and clergymen, as well as exposing their patients and efforts to the study of various social and physical research groups.

To deal with the problem effectively we must bring to treatment or control many more than has been the case to date.

All of us who come in contact with the victim of alcoholic disease must concern ourselves with our particular role in attempting to study and control this illness. There are some special groups, however, who are in first contact with these people. These are the families and the employers. Very often the family is so bound emotionally with the problem of the alcoholic that its members find themselves in a difficult position, or even powerless to take action. Some of them may be alcoholic or otherwise disturbed themselves. Even if they have some understanding of what has happened, they may be resentful and angry in their attempts to coerce a member into treatment, or they may be so fearful of continuing upsets that they dare not come to grips with the problem.

EMPLOYERS have a strong reason to be concerned with alcoholism. The majority of alcoholic males fall into the age group where they are at the peak of their producing efficiency. This means that there is a tremendous concentration of alcoholic disturbance among the work forces in industry and commerce. There are men and women who are working inefficiently, losing time, making mistakes. Employers are beginning to find that it is good business to look at this problem as they would at any other problem of disease. They are finding the cases and insisting that they get assistance, and are often willing to support and help the employe in getting the treatment he needs. It is not good treatment for an employer to be indifferent. It is not enough that a man is getting to work, or just to give him another chance when he has an absentee record. It is not enough just to fire him if he abuses that chance.

A ready solution is not at hand, nor am I going to suggest one.

It does seem, however, that recognition must be given to two broad areas of the problem. In the first instance, we must redouble our efforts at case finding and in exploring means to bring these to treatment or other control in order to interrupt the seemingly inevitable process of destruction to themselves and others. Even more important is to delineate clearly the patterns of unhealthy use, so that cases may be detected at the earliest opportunity or, even better, so that processes of education may help the individual reach for himself some decision that will avoid the adoption of an unhealthy drinking pattern.

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THE basic causes for crime have been the same for centuries. But perhaps the most disturbing feature of the rise in crime today lies in the fact that neither the absence of real poverty nor the more progressive methods employed in dealing with delinquents appear to have done anything to reduce the volume of crime.

—*Sir Joseph Simpson, Head of Scotland Yard*

Rules for obtaining happiness on this earth: There are no rules for obtaining happiness on this earth.

— *Hilaire Belloc*

SOCIOLOGICAL ASPECTS OF THE DRUG ADDICT — A National Perspective

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THERE is no such person as a typical drug addict, even though generalizations about drug addicts have frequently been made in the psychiatric literature. The group of people who have become addicted to drugs is a variegated group showing widespread sectional differences, which may be due in part to dissimilar sociological and cultural factors. In this paper, an attempt is made to describe some of the sectional differences and similarities observed in drug addicts from the Continental United States and Puerto Rico.

The following observations are impressions gleaned from psychotherapeutic contact with addicts at the Federal hospitals at Fort Worth, Texas, and Lexington, Kentucky. At Lexington, male voluntary and prisoner addicts are admitted from east of the Mississippi, together with female addicts from all over the United States. The Fort Worth Hospital admits only male addicts from west of the Mississippi, together with some patients from Puerto Rico.

The first difference noted between the populations of Lexington and Fort Worth is the racial one. Drawing its addict population mostly from large Eastern urban centers, the Lexington Hospital has shown a preponderant Negro population during recent years. The Fort Worth Hospital, although situated in an area of greater numerical Negro population, has far fewer Negro patients. Interestingly enough, the majority of the Negro patients admitted to the Fort Worth Hospital also come from the large urban centers.

I. *The Northern Negro Addict*

THE Northern Negro patient at Lexington usually comes from the lower echelon of urban society. The great majority, although superficially well nourished, have led a "hand-to-mouth" existence. A frequent hospital statement heard in reference to this group is: "Although they complain, some of them admit that they have never had it so good." Having attained a higher educational level than their Southern and Western counterparts, they demonstrate a singular unwillingness to utilize their intellectual capacities. In the Lexington Hospital, they appear to form more cohesive units than the Negroes in the Fort Worth population, with the concommitant presence of more group hostility directed toward the staff. It appears that their capacity to form more group attachments detracts from the ability of individual patients to form relationships with staff members. Breaking these patients away from the "gang code" is found to be much more difficult than with the Negro patients in Fort Worth.

The difference in intellectual motivation is seen most graphically during the psychiatric interviewing of these patients. Very commonly, a Northern Negro high school graduate in Lexington will refuse to perform simple arithmetical calculations, saying, "I have no head for figures. I'm just not interested in it." His Fort Worth counterpart, even of the eighth grade level, will perform simple calculations well, and even if he has difficulty will demonstrate great mental effort. The "elan vital" of the intellectual functioning of the Northern Negro addict seems to have been sapped by his fight for economic survival on the streets.

II. *The Southern and West Coast Negro Addicts*

THE Southern Negro addicts seen at Fort Worth and Lexington have many similarities. Cooperative, well mannered, even diffident, they rarely become members of the urban cliques. At Fort Worth, the occasional Southern Negro who engages in antisocial activity in the hospital seems to be a "lone wolf." Antisocial activity as a revolt against dependency is seldom seen here. These patients seem to accept dependent relationships on mother and maternal figures. The rural Southern Negro addicts are more likely to have stable family backgrounds and to have made better marital adjustments than the urban Southern and Northern Negro addicts.

The Fort Worth male Negro addict from the West Coast has marked differences from the Eastern and Southern urban Negro addicts. Suave, cosmopolitan, possessors of mordant wit, the great majority of these addicts have traveled widely in their continuous pursuit of pleasure. From frequent trips across the Mexican border they seem to have absorbed an "easy-goingness." They also seem to have fewer roots. If San Francisco gets tough on addicts, they go to Los Angeles. If L.A. tightens up, they go to Seattle, or Tucson, or Denver etc. The battle for economic survival on the streets seem to have sapped less of their energies. As stated previously, they form fewer cohesive groups at the Fort Worth Hospital and are easier to break away from the gangland code. But, once separated from his cohorts, the Western Negro addict has a narcissistic core that envelops him like a protective mantle against reality orientation. He smiles at the staff and in a semi-hostile way seems to say: "Okay. You have separated me from the group, you think. Really, I never was one of them anyway. First, last and always, I love me and what gives me pleasure. Nothing you have can match drugs." There is a more constant interchange between Southern Negro addicts and West Coast Negro addicts. Because of the stringent law enforcement in New Orleans, many Southern Negro addicts have migrated to the West Coast and absorbed Coast addict patterns, only to return home when they can no longer bear the strain of separation. On the West Coast, these Southern Negro addicts also come into contact with the Eastern Negro addicts. There seems to be little interchange between the Southern Negro addict and his counterparts in New York and Chicago.

III. *Addicts from the Spanish Culture*

SPANISH-SPEAKING groups of addicts are seen at both the Fort Worth and Lexington hospitals. The Puerto Rican group is common to both hospitals, but are numerically greater at Fort Worth, since many patients are sent there directly from Puerto Rico. The Fort Worth Hospital also has a unique group of Mexican-American patients, with its close proximity to the Mexican-American culture in San Antonio, Albuquerque and Southern California.

First let us consider the Puerto Rican group. It is observed that the future Puerto Rican addict usually starts using drugs on a visit or

a prolonged stay in New York or some other urban center, rather than starting in Puerto Rico. The author has been impressed, at both the Fort Worth and Lexington hospitals, with the presence of two main groups of Puerto Rican addicts. These groups may be called descriptively the "quiet group" and the "raucous group." The "quiet group" tends to look with disdain on the "raucous group," and even the Spanish cultural bond and common language do not lead to close relationships between these groups.

The representative of the "quiet group" is usually better educated than is his "raucous group" contemporary. Although he is more introspective, he reads a great deal and has a wide interest in current events. He is a sort of "citizen of two worlds," since he maintains an active interest in both the Spanish and English cultures. If he has had a previous antisocial background, he looks upon it more as a stage of playfulness rather than as a way of life. Often, having broken away from his religious heritage, he possesses an active conscience that frequently impels him to return to the fold. He maintains an interest in music, but prefers modulated tones to primitive beats. Naturally seclusive, he seems to be pervaded by a sense of loneliness.

The "raucous" Puerto Rican addict group is usually derived from a lower economic class than the other group. A representative of this group typically has less education if he has lived in New York, or little or no formal schooling if he has lived mostly in Puerto Rico. Since he externalizes most of his conflicts, he seems to be almost devoid of overt anxiety. He appears as a mixture of perpetual adolescence and childish primitiveness. He has a preoccupation with himself, but little interest in self-understanding. For him, English culture is something to be reckoned with, since it interferes with his hedonistic designs. Naturally outgoing, he is prone to sudden outbursts of fear and rage of almost uncontrollable proportions.

The Mexican-American group in Fort Worth, although often associating with the Puerto Rican group, comes from a Spanish culture that dwells apart. These patients come from a matriarchal culture that really represents the essence of "Momism" (and "Grandmomism"). Even those who revolt against these firm ties through the medium of antisocial behavior utilize this behavior almost solely with men and become timid when confronted by aggressive females. The Mexican-American addict group is characterized by an extreme passivity that

often borders on lethargy. This passivity pervades their whole being. They move slowly, and during psychiatric interviewing seem to have psychomotor retardation. They accept punishment with a kind of stoical disinterest. Their considerable talents as individuals seem to exist in a dormant state. They seem to be constricted and chained, but not desirous of release. Hospital staff members have said that they would like to "shake them until they rattle" to release some of their potentialities. These patients come from a very low economic status and have almost insurmountable difficulties in obtaining employment after being discharged from the hospital.

IV. *The Chinese Addict*

THE Fort Worth Hospital admits a small group of Chinese addicts from the West Coast and from the Southern United States. The Lexington Hospital has a smaller group, mostly from New York. In both institutions the Chinese patients maintain the group cohesiveness that is typical of their culture. It is only in rare instances that they provide an "open door" for the staff to observe their behavior. They dislike washing their dirty linen in public. Few Chinese addicts are seen while they are in their twenties' and thirties'. The older Chinese patients accept the opium pipe as part of their culture and think it peculiar that smoking it is regarded in the West as an offense against the law. When given prison sentences they serve their time with resignation, remaining to themselves, aloof and inscrutable. Few elderly Chinese patients from the West Coast use herion, in spite of its being plentiful there. Heroin use appears to be more prevalent among the Chinese addicts from New York.

An occurrence that is disquieting to the Chinese population itself is the appearance of a new generation of Chinese addicts. This is the second-generation American-born Chinese addict. He scorns opium as old-fashioned and seeks the quicker take-off of heroin and dilaudid. He is more apt to engage in antisocial activity, including the greatly tabooed stealing. Narcotics use for him seems to represent an unsuccessful emancipation proclamation from his forebears.

V. *The Caucasian Male Addict*

THE most striking difference between the Caucasian male addicts at the Fort Worth and Lexington hospitals is in their widely diver-

gent addiction histories. Use of drugs in the large Eastern urban centers appears to begin at an earlier age than in other areas. Thus the average Lexington addict at, say age 25, has a longer addiction history than the average 25-year-old Fort Worth Caucasian male addict. Many more young addicts, who have been addicted to drugs for short periods of time, are seen at Fort Worth than at Lexington.

Since the Lexington young Caucasian male addict appears well on the way to becoming a recidivist when he first arrives, a few words must be said about the recidivists at Lexington and at Fort Worth. First, in keeping with the changing picture of drug addiction, there are very few Negro recidivists from all parts of the United States. Among the Caucasian recidivists, sectional differences are apparent. In Lexington, we see many old-timers among the addict volunteers, who consider the hospital as "a home away from home." They will remain for full treatment, often overstaying their treatment time. In Fort Worth, more Caucasian recidivists seem to enter for tapering down their drug use, and fewer wish to remain for psychiatric treatment. Personality traits of these addicts are monotonously similar. A real injury often directly anteceded their addiction. Tolerance to real or imagined pain is of the lowest level in these patients. Having cut themselves loose from familial ties at an early age, they live a nomadic and desultory existence, devoid of self-respect or feeling for others. They will often approach the climacteric with a feeling of futility and a sudden motivation to cease drug use, but later will accept with resignation the dismal prospect of trying to change a thoroughly ingrained pattern. At Lexington we have seen a considerable number of these Caucasian climacteric addicts.

It is difficult to describe the sectional difference of the young Caucasian male addicts. The Eastern and Southern representatives generally come from a lower socio-economic class than their Western counterparts. The young Northern Caucasian addicts, like the Northern Negro addicts, demonstrate a lack of capacity to utilize their intellectual potentials. But, compared with the Northern Negro patients, more of their previously mentioned "elan vital" remains, and they have a greater capacity for group attachments and interpersonal relations. The young West Coast Caucasian male addict also shares many traits with the young Northern Negro addict from the large urban centers.

Breaking the young Caucasian male West Coast addict away from the "gang code" is as difficult as separating the young Northern Negro addict from the "gang code" in Lexington. He remains aloof and demonstrates little of the sophistication of convivial spirit of the young Negro addict from the Coast. His narcissism appears as a superficial, imperfect covering rather than as a hardened core. Stripping the outer layer of his defensive armor, rather easily done once the difficult task of separating him from the "gang code" has been accomplished, leaves him exposed to internal and external danger, and he may either flee in panic or become painfully aware of his unlimited need for dependency. He has a sense of loneliness, similar to the members of the "quiet" Puerto Rican group. Thus this group of patients, although presenting a dismal initial appearance, later proves to contain more good psychotherapeutic prospects than the superficially friendly and sophisticated young Negro group from the West Coast.

VI. Female Addicts

At Lexington, female addicts are seen from all sections of the United States. These patients encompass all of the ethnic groups already discussed, with the exception that Chinese and Mexican- American female addicts are rarely seen. First, we may list two striking differences between the female and male addict populations as a whole. Barbiturate use is more common in the female addict, and a larger percentage of the female addicts take both barbiturates and narcotics than do the male addicts. Then, once withdrawn from drugs, the female addicts, as a group, show an enormous preoccupation with minor somatic complaints.

Often doomed to support others' habits, in addition to their own, the female addicts have almost invariably engaged in prostitution as a source of income. The only ones who escape this fate are some elderly former nurses and some females from rural communities, who procure drugs from legal sources.

As with the Negro male population, few Negro female recidivists are seen. The large majority of the Negro female addicts at Lexington are from the heavily populated urban centers east of the Mississippi. They demonstrate the same type of intellectual inhibition and lack of "elan vital" as their male counterparts. They also demonstrate much more overt hostility when their insatiable demands for medication are

not met and when quick ministration is not given to their psychosomatic complaints.

The Puerto Rican female addicts cannot be divided into groups like the Puerto Rican male addicts. They have diffuse characteristics that defy categorization. Some are brazenly amoral, others have pristine pretentions. The Puerto Rican female patient who appears superficially quiet may suddenly burst forth with a raucous display of primitive behavior. They are more expert at manipulation than the Puerto Rican males. The whole group has a self-preoccupation without having a penchant for self-understanding.

The young Caucasian female addicts, like the young Caucasian male addicts, also show great sectional differences. The West Coast group show a close similarity to their male counterparts. They also come from a higher economic class, have little group feeling and have a superficial, imperfect, narcissistic covering, beneath which lies a deep loneliness and a search for dependency. As with the West Coast Caucasian male addicts, these patients offer far better therapeutic prospects once their defensive armor has been penetrated. The Eastern Caucasian female addict is usually older than her Negro contemporary. When seen at the Lexington Hospital, this group is usually well on the way to recidivism and is very recalcitrant to change. It appears that more and more young Negro and Puerto Rican females are becoming addicted, and that they are pushing the young Caucasian females out of the Lexington population.

SUMMARY

This paper has presented observations on the sociological and cultural differences seen in drug addicts from all sections of the continental United States and Puerto Rico. Since the drug addict may arise from many varied cultures with dissimilar sociological stresses, it appears that the area of social factors in drug addiction represents a fertile field for future research.

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PSYCHIATRIC TESTIMONY IN MILITARY AND CIVILIAN COURTS

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PSYCHIATRIC testimony, whether in military or civilian courts, may be based on the hypothetical question, or it may depend on the conclusions drawn by the expert after a careful and detailed examination of the person in question. The expert's opinion may be requested in both criminal and civil cases. The psychiatrist may have to appear before the judge alone, or in the presence of a jury, prepared to defend his conclusions. A written report or deposition may be the only statement required, but in submitting such an opinion the expert opens himself to subpoena for possible cross-examination.

Usdin[1] points out that the psychiatrist "faces the problem of providing expert testimony in a foreign milieu and on the basis of criteria set by law. These criteria may appear quite ambiguous or may be satisfied in such a manner that the physician may believe that injustice is being done. He may be disconcerted by some of the discourtesies and lack of weight afforded his testimony. He should remember not only that law is an adversary process but also that the court often has access to information that the physician lacks. The lawyer's duty to his client is to give him the benefit of the best legal ability of which he is capable, so that a lawyer, consulting a physician, will naturally try to present witnesses who primarily favor his side."

Usdin[2] writes again: "There is increasing awareness on the part of the legal profession of the real contributions which an understanding of behavioral mechanisms can make toward better conceptualization of the law and its procedures. Psychiatry is the medical specialty which has the closest contact with the law. It, too, is directly concerned with the appropriate regulation of human behavior in a healthy manner. Psychiatry, however, is neither as pragmatic, authoritarian or precise as is the law. Present-day dynamic psychiatry emphasizes the vital impact of unconscious motivation of behavior; the law has manifested definite reservations in the application of such concepts."

The debate now raging in the courts, in the literature and in conferences between lawyer and lawyer, lawyer and psychiatrist, and psychiatrist and psychiatrist, may well lead to changes in the rules which assist courts, both civilian and military, to come to findings concerning insanity and mental responsibility more in accordance with "modern" psychiatric concepts. As early as Isaac Ray in 1838, doctors have been decrying the lack of concordance between stable set law and flexible moving, hopefully progressive psychiatric knowledge. This debate has been raging full force since the McNaghten Rules were laid down in 1843. These rules, still law in forty-seven states, specify that there can be no defense of "insanity" if the individual knows the nature and quality of his act, and knows that it is morally wrong. As Guttmacher[3] states: "The McNaghten Rules is of course not a nineteenth-century effort to isolate the psychotic offenders. It is an effort to pick from the mass of criminal offenders those individuals when mental illness renders them non-deterrable by threat of punishment, and where punishment would not serve as a salutary example in deterring others from similar antisocial behavior. The end is a worthy one. But if the courts must rely largely upon psychiatrists to assist them in making such a determination, one can hardly imagine clumsier and more ineffectual devices than the old 'right and wrong formula', 'the yes or no' questions propounded by lawyers, and the partisan role of the expert to achieve it."

THERE is thus more at stake than these rules. Even the addition of the relatively modern, well established doctrine of "irresistible impulse," as pronounced in 1929 by the Court of Appeals in the Case of Smith vs. U. S., did little to free the psychiatrist to assist the court. Often the court could not understand this concept, or the concept had

to be bent to fit the at times well laid plans of the psychotic, which certainly are far from "impulsive."

Although the New Hampshire Rule had been in force in that state since 1869, the Durham decision in 1954 in the District of Columbia Court of Appeals has been hailed by some and decried by others. By this decision, to allow a plea of insanity, it would be only necessary to demonstrate the existence of a mental disease, and that the act charged was a product of that disease. There are those who hail this decision as the increased use of enlightened psychiatry, while there are those who feel it could be used by skillful lawyers, employing its literal meaning, to "get off" those who should be punished. Thus it has not been adopted in any state. No one can doubt, however, the important place earned by Dr. Joseph L. Gilbert, who, by his refusal to answer with a "yes" or "no" the traditional questions, set up the background for the court's controversial decision.[4]

Whether or not one feels that the consideration of antisocial acts as the products of mental disease is too "dangerously" vague a concept, one cannot help but wish that more lawyers and psychiatrists would recognize the basic truth propounded by a great lawyer, Simon E. Sobol-off, when he said, "We know today that the external manifestations of mental disease follow no neat pattern permitting pat legal definitions suitable for universal application."[4]

The senior author since 1928 has had the opportunity to examine 6,356 court cases, of which only ninety-two were civil cases, and eighteen involved the charge of murder. Of all the cases examined, the diagnoses were:[5]

Psychiatric classification	*Percentage distribution*
Normal	36.20
Mental deficiency	9.80
Disorders caused by impairment of brain tissue function	4.50
Psychoneurotic reactions	2.70
Psychotic reactions	6.30
Personality pattern disturbances	3.95
Sociopathic personality disturbances	36.55

How can a pragmatic rule requiring a yes or no answer do justice to the true situation in these 6,356 persons?

The chief area of concern for potential abuse of psychiatric testimony under so non-structured framework as the Durham Decision is that which deals with the criminal responsibility of the personality pattern disturbances, sociopathic personality disturbances and, to a lesser extent, the severe psychoneurotic reactions. Under present rules, they seem to fall into an area intermediate between relative responsibility and irresponsibility. Such persons do not qualify as irresponsible on the basis of the "right and wrong test." They do know the nature, consequences and wrongfulness of their acts. Neither do they clearly qualify as irresponsible under the "irresistible impulse" test, for they do not entirely disregard the nature of the surrounding circumstances in committing their acts. Yet, we as psychiatrists cannot help but realize that their acts are affected by their abnormal emotional adjustment or maladjustment. Dealing with the "insane," the lawyer Soboloff[4] catches a psychiatric "truth" when he states: "Since insanity does not only or primarily affect the cognitive or intellectual faculties, but affects the whole personality of the patient, including both the will and the emotions, an insane person may therefore often know the nature and quality of his act, and that it is wrong and forbidden by law, and yet commit it as a result of the mental disease." How can these concepts best be brought to courts by expert witnesses?

THE junior author, in examining and preparing briefs on military cases over a period of two years, examining every prisoner who passed through U. S. Army Fort Campbell stockade, has had the opportunity to decide that, far from being behind its civilian counterpart, the military court has many points of superiority to the usual civilian system.

As stated, all prisoners, many on pre-trial confinement, were examined. Those requiring full psychiatric work-up, whether because of apparent psychiatric conditions or because of involved medico-legal complications, were referred to the Mental Hygiene Consultation Service. There, questions were often settled by presentation to a full staff, with the resultant brief a synthesis of opinions. Fortunately, in the military situation, no one in whom an overt psychosis is felt to be present need ever be brought to trial. By medical decision, he can be handled properly by medical channels. If indicated, defendents not confined were given similar full work-ups. When a final certificate

was formulated, and an individual was felt competent to stand trial and assist in his own defense, certificates were given to both prosecution and defense for their mutual examination and use. If the information contained in such a report was of use to one more than the other, it was still presented in court impartially and respected as such by the court.

In a military trial, there is first the issue of guilt or innocence. Since no one felt to be innocent by reason of insanity comes to trial, the psychiatrist was more usually utilized by the court in the process of mitigation and sentencing. After the determination of guilt or innocence, the same court, acting in its dual role of jury and judge, determines the proper disposition of the offender. It was at this point that psychiatric testimony was usually utilized.

DURING the war a manual, TM 8-240, was prepared for the guidance of young psychiatrists in the strange atmosphere of military courts. Previously, it has been felt that due to TM 8-240 the military psychiatrist was restricted in his testimony to the exclusion of his individual beliefs. Although this technical manual is in the process of revision, it has been the experience of the junior author that, while useful as a guide to the young military psychiatrist, it is in no manner binding. Rosner[6] has so well pointed out that the U. S. Military Court of Appeals, in decisions ranging from United States vs. Smith to United States vs. Covert, has freed the psychiatrist from restrictive regulations to testify fully in dynamic, if simple and realistic terms to the military courts. These courts wish only to function properly and intelligently. The Durham Rule has not been accepted as a replacement for the McNaghten test plus the test of irresistible impulse, but considerable latitude has been opened in helping the courts to understand how any particular "mental defect, disease or derangement" affects the ability to adhere to the right. Such testimony is most useful in terms of mitigation, in setting the sentence, rather than in the determination of guilt, which is surely a legal matter.

While working within the framework of the Manual for Courts Martial and TM 8-240, which specifies the necessity of specific answers to the defendant's ability, insofar as the particular act charged, to differentiate between right and wrong and to adhere to the right, it is made very clear that it is also the psychiatrist's duty to "enlighten the

court on the pathology and symptoms of the particular mental disease or disorder," and "to explain the effects of such symptoms or such mental disease or disorder on the accused's mental ability to realize the act charged is wrong and to control his conduct and adhere to the right."[7] Properly interpreted, this certainly gives much leeway to the doctor who does not pontificate, but who speaks simply, honestly and directly along these lines, admitting his limitations. Given the opportunity to explain his findings fully, the psychiatrist may appear less arbitrary or mystic than is sometimes the case in civilian courts.

Frequently, the psychiatrist finds himself the bewildered tool of the adversary process which is the law. When he testifies for defense or prosecution, he is often considered as identified with one or the other, with a resultant diminution in the considered scientific weight of his testimony. While many places have provision for use of the impartial medical expert, as in Massachusetts by the Briggs Law, too seldom are they utilized. Great care was exercised to testify always for the court, rather than for or against the defendant. Laymen, let alone psychiatrists, are disturbed by a psychiatrist who states, "I have never lost a case." As expert witnesses, they are not *ours* to lose. When thus involved in the adversary process, such testimony is necessarily reduced in significance in the eyes of the jury.

WHILE some civilian jurisdictions such as Baltimore and New York do use psychiatric examinations and briefs to assist the judge in proper sentencing, too often the emphasis in psychiatric testimony lies elsewhere. The military system makes greatest use of psychiatric testimony in just this matter of disposition. Many feel that this is a proper use of psychiatry. Not only is it implicit in debates on intermediate gradations of responsibility, but it has been specifically recommended by many.

Sociopaths committed by law indefinitely to Saint Elizabeths after being found not guilty by application of the Durham Rule have found the defense no "easy way out." Waelder's[8] concept is advanced by many psychiatrists and lawyers. He feels that the psychiatrist should assist the courts in proper sentencing by answering three questions: Is he dangerous? Is he deterrable? And is he treatable by medical or educational methods? Roche[9] in propounding a philsophy of basic universal responsibility, similarly feels that assistance in sensible disposition of

the offender should be our major responsibility. If all are responsible and are to be confined, the main assistance of psychiatry is logically in recommending treatment for the treatable. Society is protected rather than merely revenged.

Not only then does psychiatry properly assist in findings regarding the individual's capacity to form the intent (fixing the line between "responsibility" and "irresponsibility") but also, by making these intermediate gradations of responsibility clear to the court, the psychiatrist assists in the disposition. By the very nature of the military system, once guilt or innocence is established, detailed testimony for the sole purpose of determining sentence is required. Intelligent complete psychiatric testimony to assist the court is thus possible and appreciated. Many of the issues involved in debates over the rules as they concern sociopaths and severe psychoneurotics could be resolved if a similar approach by the psychiatrist in civilian courts were possible.

CONCLUSIONS

CERTAIN conclusions, not original, are supported by our experience. There is a crying need for improvement in the application of sound psychiatric principles to the law.

1. Psychiatrists should be called by the court, or a panel of psychiatrists called both by prosecution and defense should jointly examine the defendant. The first approach would tend to eliminate the battle of experts if the unbiased nature of the expert called in such manner were accepted. The adversary process which is the law certainly has adversely affected the significance of psychiatric testimony.

2. There should be freedom for the expert to testify to the whole truth. It is understandable why juries look with a jaundiced eye on testimony which is not explained, and which they must accept without an explanation. A jury is entitled to know how the psychiatrist reached his opinion. Recognizably, this might involve a change in the rules of evidence, for certain facets of psychiatric examination are now classifiable in a literal sense as hearsay evidence.

3. There needs to be a recognition of diminished responsibility where applicable. This is best applied in sentencing or disposition, as long as full accountability to society is maintained, and as long as that society is safeguarded by the use of indeterminate sentences where justified.

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WE spend billions to explore outer space, but we balk at spending millions on living space. I am unable to understand the philosophy of government which treats the cities as beggars at the backdoor.

— Hubert H. Humphrey

Fanatic love of virtue has done more to damage men and destroy societies than all the vices put together.

—R. L. Bruckberger

If nobody ever said anything unless he knew what he was talking about, a ghastly hush would descend upon the earth.

— A. P. Herbert

GROUP THERAPY WITH HOMOSEXUALS

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HOMOSEXUALITY is the preference by an individual for a person of the same sex as a sexual companion, rather than a person of the opposite sex. It is an anomaly that is encountered in persons in all walks of life and afflicts both men and women. It is not recognizable by physical signs alone, and frequently male and female homosexuals are indistinguishable in body structure, voice timber or general behavior from "normal" heterosexual individuals. In the United States, under the designation of sodomy and crimes against nature, homosexual activity violates penal statutes and is prohibited.

The law in Western society has considered sodomy, crimes against nature and homosexual behavior as serious perversions, the free choice of depraved individuals and the product of vicious desires. Moreover, judges and legislators have labored under the impression that the proscribed forms of sexual behavior are comparatively rare. However, present-day research has cast doubt upon these premises. The Kinsey Report[3] contains an analysis of the incidence and frequencies of orgasms through six sexual outlets: masturbation, nocturnal emissions, heterosexual petting, intercourse (premarital, marital, extramarital, postmarital and intercourse with prostitutes), homosexual outlets and animal outlets. It indicates that at some period in their lifetime more than one-third of American males have had experience in homosexual activities resulting in orgasm.

Popular thinking has created a stereotype of a "sex psychopath" which includes not only the degenerates who prey on young children or engage in sexual delinquencies accompanied by acts of violence, but also covers other sex deviates: exhibitionists, peepers and homosexuals. Tappan pointed out that "two-thirds of the psychiatric authorities consulted by the writer pointed to the wide disagreement among psychiatrists as to the meaning of the term 'sex psychopath.'"[5]

Unfortunately, even among many physicians there is a wide range of attitudes concerning homosexuality; and to many medical doctors, homosexuals are a revolting group of individuals who are perceived as social outcasts.

In the United States, during the last twenty years, the legislators of several states have reacted to community pressure because of a number of serious sexual attacks and have hurriedly enacted "sexual psychopath" laws. However, the fact remains, as Sutherland reminded us, "no one has been able to identify a sexual psychopath any more than any other psychopath, and as a result the laws have been absurd in principle and futile in operation."[4]

In England, however, a more reasonable approach toward the handling of sexual offenses seems to be in the making. During September, 1957, the Wolfenden Report[7] was published, indicating that there is a general measure of agreement on two propositions: (1) that there exists in certain persons a homosexual propensity that varies quantitatively in different individuals, and (2) that this propensity can affect behavior in a variety of ways, some of which are not obviously sexual.

The report goes into other facets of the problem posed by therapeutic measures, highlighting the following:

> We have earlier made it clear that although homosexual behavior in some cases may result from disease, the evidence placed before us has not established to our satisfaction the proposition that homosexuality is a disease. This does not mean, however, that it is not susceptible to treatment. As we explain elsewhere, psychiatrists deal regularly with problems of personality which are not regarded as diseases. It seems to us that the academic question whether homosexuality is a disease is of much less importance than the practical question of the extent to which, and the ways in which, treatment can help those in whom the condition exists.
>
> In this connection, it is important to consider what the objectives of this help should be. It seems to us that these may be one or more of the following. First, a change in the direction of the sexual preference; secondly, a better adaptation to life in general; and thirdly, greater continence or self-control. Success in achieving one of these objectives may help in achieving another.[6]

Goals of Treatment

WHATEVER the high hopes of all therapists treating homosexuals may be for a complete change of his patients into ideal com-

pletely masculine heroes, the majority of psychotherapists are content to achieve more limited goals. This was emphasized by Thompson in describing the activities of a forensic clinic, as follows:

> It must be admitted that in no case does the improvement constitute a complete change from homosexuality to heterosexuality. In a small number of cases there have been definite movements in this direction, but none have been complete as yet. The improvements have been more in the nature of greater acceptance of homosexuality, inhibition of acting out, diminution of anxiety and improvement in the neurotic aspects of the problem.[6]

There is an additional component which should not be overlooked in the treatment of homosexuals. This involves not only the problems that apply to the homosexual as a member of a minority group, but also the psychological maladjustments from which members of the "normal" population suffer and for which they may receive treatment.

Setting

THE BARO Civic Center Clinic in Brooklyn is an agency that is unique in the history of therapy in America. It is the only full-time, licensed privately endowed mental hygiene clinic devoted exclusively to the psychiatric treatment of adult offenders. It was organized in 1953 by a group of public-spirited citizens under the direct supervision of Dr. Ralph S. Banay.

By 1954, among other innovations, a group therapy program for offenders was established, designed to treat individuals referred by various criminal courts, agencies and other sources. At first the therapy groups excluded homosexuals, although all other types of offenders were welcomed. In the fall of 1956, a number of homosexuals were invited to an on-going therapy group. They participated enthusiastically in the group interaction, but refrained from discussing the sexual practices that had been responsible for their coming to the clinic. Finally, one of the patients spoke with the therapist privately after one of the sessions. He explained that, while he found the group sessions valuable, he felt that he was unable to present his own problems which were connected with his sexual difficulty. He suggested that he, for one, would be comfortable only in a homogeneous therapy group of homosexuals. In that setting he would be able to speak freely about his psychological difficulties.

This experience corroborates the findings of Hadden who writes, "From early experience with group psychotherapy I learned that the average homosexual had known such vigorous rejection by society that he was unable to present his problem before the therapeutic group."[2]

Our experience at the clinic had demonstrated the wisdom of forming therapy consisting exclusively of homosexuals. These patients, once they were organized into a homogeneous group, discussed not only their anxieties involved in their sexual maladjustments, but also the matters generally discussed in the "normal" group of offenders. Most of the original group of homosexuals remained in treatment long after jurisdiction of the court or agency that referred them had expired. These patients remained with the therapy group until they felt that they had benefited to a maximum degree. They terminated contact with the therapy group in a planned manner and explained what changes had taken place in their feelings and perceptions.

Typical Cases

PETER is 22, the only child born of an Oriental father and an Irish-American mother. When he was 10 his parents were divorced and he remained with his father, who did not remarry. His mother moved out of the city, where she married again and had a number of children. Peter is a devout Catholic who graduated from a parochial elementary and secondary school. At 17 he came to the attention of the Youth Counsel Bureau because of the theft of an automobile, but at that time he was not referred for treatment. Five years later he voluntarily came into the Youth Counsel Bureau, asked for psychiatric help and was referred to the BARO Clinic. He was unhappy in his job, was living with a homosexual with whom he had been engaging in sex relations, and complained of his inability to control his excessive masturbation. He felt guilt-ridden about his feelings about sex. The closest he ever came to having heterosexual relations occurred when he was 16. At that time he slept at a relative's house and an older girl cousin came into bed with him. He started to have intercourse but was unable to continue. Afterward he was attracted into having homosexual relations.

At the clinic he was diagnosed as a schizoid personality and neurotic personality (anxiety reaction). Because it was felt that his basic

difficulty was in the sexual area stemming from his homosexual practices, he was referred to the therapy group of homosexuals. In the therapy group Peter participated enthusiastically and intelligently. He exhibited a great deal of insight into his problems and the problems of the other group members. During the course of the meetings he appeared to work out his feelings toward religion and his feeling of guilt concerning his attitude toward having heterosexual relations. He ceased his homosexual activity, started to have heterosexual relations and worked through his feelings toward religion so that he no longer had his intense feelings of guilt. Finally, he matriculated in the evening session of a college and changed to a job in which he was much happier. He continued in the homosexual therapy group for about two years and withdrew when he felt that he had benefited greatly and could continue on his own. His projective drawing tests given at the start of therapy, during the course of treatment, and at the conclusion of treatment, showed a marked diminution of anxiety and a greater acceptance of a masculine role. Before his discharge, Peter appeared before a staff conference, where it was agreed that he had made marked progress.

ALFRED, at 32, was the oldest member of the group. He was a small-boned, light-skinned Negro with delicate features. He had been referred to the clinic by the Probation Department of the Court of Special Sessions following his arrest in a subway toilet for manipulating the penis of a 15-year-old boy. He was married and had a 6-year-old daughter, but was not living compatibly with his wife, who was suspicious that all of Alfred's friends were homosexuals. At the clinic, Alfred scored an I.Q. of 125 and was diagnosed as a homosexual with a great deal of guilt and having low self-esteem. He was unsure of himself and stuttered when nervous. He was assigned to the therapy group of homosexuals, where he attended for two years without absences.

Initially Alfred was quiet in the group, although he appeared extremely interested in the interaction of the more vocal group members. After a while he participated more frequently and was able to give the group the point of view of a married man who had a child. His low point came when he lost a job and became depressed and

discouraged. The clinic came to his rescue when he was referred to a job by the vocational counselor.

As Alfred continued to attend group sessions, he told of his improvement in his relations with his wife and his better adjustment on his job. His entire outlook seemed to change in a more positive way. His projective drawing tests, given at the beginning of therapy, during the course of treatment and when he was ready to drop out, reflected his lessening of anxiety and a better acceptance of the difference between male and female sex roles. Marked improvement was noted by the staff when Alfred was presented at a conference at the time he asked to be discharged.

FRANK was an only child who completed two years of college. He was 22 years of age and had an I.Q. of 126. When he was a teen-ager he started having homosexual relations with young boys, and he estimated that he must have participated in these activities over two hundred times with a countless number of young boys. When his difficulties became known to his parents, he was referred for individual psychiatric treatment. However, this treatment did nothing except develop his ability to intellectualize his problems. It was only after he was arrested for committing a homosexual act with a young schoolboy and came before the Court of Special Sessions that he was referred to the clinic. Here he was diagnosed as a schizoid personality and an emotionally unstable individual whose prognosis was guarded. Initially he was placed in an undifferentiated group where he participated to a limited extent but did not discuss his problem of homosexuality. As a matter of fact, it was Frank who suggested that a therapy group of homosexuals be established so that individuals with problems in that area would not feel ashamed of discussing their problems with people in a similar situation.

As soon as a therapy group of homosexuals was established, Frank started to discuss his problems. In addition, he related well with the other group members and discussed the problems of others with a great deal of empathy. While he was receiving treatment he was meeting with the vocational advisor, who steered him into employment he liked.

At the end of two years, some months after he had been discharged from probation, he voluntarily asked to be discharged from

treatment. His projective drawing tests reflected improvement with respect to his attitude toward sexual figures. Just before his discharge he discussed his plans of marriage with the group and a month later he was married.

MAURICE was an 18-year-old youth of average intelligence who had graduated from high school and entered a junior college fashion school. He had engaged in homosexual activities from his early teens, but did not get into difficulty until he was arrested in a public toilet when he made advances to a vice squad plainclothes detective. He was turned over to the Youth Counsel Bureau, which referred him to the BARO Clinic. At the clinic he was diagnosed as a homosexual and referred to the homosexual therapy group for treatment.

For almost a year Maurice did nothing more than listen attentively. Finally, he started to discuss not only his problems in the sexual area, but also his familial relationships.

Maurice remained in the group for two years, a year beyond the time the referring agency terminated its contact with him. In the group sessions he seemed to be looking for a method of adjustment rather than a complete change toward heterosexuality. His projective drawings indicated a better adjustment in all areas. At the staff conference prior to his leaving the clinic, Maurice impressed the staff with his general improvement.

Discussion

AT the BARO Clinic we have observed that the attitudes of homosexuals who have undergone group therapy have changed with respect to social conformity: one of the group members has undertaken marriage, another has started to have heterosexual intercourse exclusively, a third has come to accept his problem more realistically, etc. These, you will note, are limited to "more in the nature of greater acceptance of homosexuality, inhibition of acting out, diminution of anxiety and improvement in the neurotic aspects of the problem."[6]

We may explain these changes on the basis that the homosexual offender has become a member of a primary group composed of patients who have passed with him through the trauma of arrest and conviction, and are now engaged within the therapy group of defining

a more conforming sexual adjustment which is stimulated, first, by the role prescription of the treatment setting and, secondly, by the accepting, permissive, "client-centered" approach of the group therapist within a Rogerian frame of reference.

It has been observed at the clinic, and also by Foulkes[1], that the group therapist may be "disturbed" by the passivity of the group. "In fact, there are long silences and one member of the group sleeps at times. It would appear that the group's demand to be given something (magical) by the conductor provokes his reaction."[1] As a result the therapist, in a group which exhibits this extreme passivity, at the beginning of some sessions takes a more active role with respect to subtly bringing up problems for discussion, but at all times he refrains from interpretations, evaluations and probing. Of course, once the group has "taken hold," the therapist resumes the classic approach of the Rogerian therapist.

As treatment progresses, the homosexual offender apparently becomes increasingly motivated to assume a more conforming sexual role as his ego defenses relax and he finds it possible to communicate about his attitude toward sexual intercourse, his feeling of status frustration, his concepts of society and his other problems which are similar to those of the larger population. At the end, if treatment progresses according to course, he may acquire the same satisfying kinds of role patterns of law-abiding behavior he formerly was able to obtain only from homosexual intercouse.

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THE RESPONSE OF PRISON INMATES TO MMPI SUBSCALES

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In recent years the emphasis has shifted in MMPI analysis from the study of the ability of each individual scale to make an appropriate psychiatric discrimination to the study of total profile configuration. Rather than depend on single scale elevations, clinical workers began to describe their interpretations in terms of profile slope, depression and peakness. As total profile analysis became predominant, the question arose as to whether additional precision could be achieved by subscale analysis. Harris and Lingoes[1], in pursuing this line of reasoning, have presented subscale clusters of items for six of the MMPI clinical scales — D, Hy, Pd, Pa, Sc and Ma. In deriving the subscales, the items scored in each of the six scales were examined, and those that seemed to reflect a single attitude or trait were grouped into a subscale. Each subscale was subjectively given a name which appeared to be descriptive of the attitude or trait underlying the items when answered in the scored direction. Unfortunately, the norms presented for the subscales are derived from a small clinical sample of only fifty cases selected from the University of California's Langley Porter Clinic. Employment of such norms puts considerable limitation on the effectiveness of the subscales; however, if the interpretation is largely confined to the relative standing of one subscale to another the enrichment of profile meaning should be enhanced. The purpose of this study is to compare the responses of white and Negro prison inmates to the Harris-Lingoes subscales and in addition to compare the inmate responses with the responses of the clinical sample of fifty cases employed in establishing the subscale norms.

Method

THE valid MMPI records of 1,096 white and 458 Negro prison inmates confined in the North Carolina prison system were scored on the following Harris-Lingoes subscales for the MMPI:

Subscale	*Number of Items*
DEPRESSION	
D 1 Subjective Depression	32
D 2 Psychomotor Retardation	15
D 3 Complaints about Physical Malfunctions	11
D 4 Mental Dullness	15
D 5 Brooding	10
HYSTERIA	
Hy 1 Denial of Social Anxiety	6
Hy 2 Need for Affection and Reinforcement	12
Hy 3 Lassitude-Malaise	15
Hy 4 Somatic Complaints	17
Hy 5 Inhibition of Aggression	7
PSYCHOPATHIC DEVIATE	
Pd 1 Familial Discord	11
Pd 2 Authority Conflict	11
Pd 3 Social Imperturbability	12
Pd 4A Social Alienation	18
Pd 4B Self Alienation	15
PARANOIA	
Pa 1 Ideas of External Influence	17
Pa 2 Poignancy	9
Pa 3 Affirmation of Moral Virtue	9
SCHIZOPHRENIA	
Sc 1A Social Alienation	21
Sc 1B Emotional Alienation	11
Sc 2A Lack of Ego Mastery-Cognitive	10
Sc 2B Lack of Ego Mastery-Conative	14
Sc 2C Lack of Ego Mastery-Defect of Inhibition and Control	11
Sc 3 Sensorimotor Dissociation	20
HYPOMANIA	
Ma 1 Amorality	6
Ma 2 Psychomotor Acceleration	11
Ma 3 Imperturbability	8
Ma 4 Ego Inflation	9

The subscale means and standard deviations for the white and Negro groups were computed and compared for significant differences in mean scores. The t-test was employed to determine the significant level of the mean differences. Subscales Pd2, Pa1, Sc1A and Ma4 were

the only subscales producing mean differences significant beyond the .01 level of confidence. The white and Negro means on these four subscales were retained for further comparison with the Harris-Lingoes clinical sample means, and the white and Negro means on the remaining twenty-four subscales were combined to form a total inmate group. The subscale means of this total group were then compared to the means of the clinical sample.

Results and Discussion

Table 1 presents the comparison of the raw score means and standard deviations of the white and Negro groups and the clinical sample on the four subscales producing significant mean differences beyond the .01 level of confidence in the white-Negro comparison. Examination of the table reveals that the white group produces a predominantly higher mean score on the Pd2 subscale than either the Negro or clinical sample. This appears to imply that the Pd scale scores of the whites are considerably more charged with authority conflict factors which would be characterized by resentment of social demands, acting out aggression in response to frustration and lack of identification with socially accepted patterns of behavior. The whites score significantly higher than the clinicals on the Pa1 subscale, implying a greater degree of paranoid ideation; however, the whites are in turn significantly lower in this respect than the Negroes. The significantly higher mean

TABLE 1. COMPARISON OF MEANS AND STANDARD DEVIATIONS ON MMPI SUBSCALES PRODUCING SIGNIFICANT MEANS DIFFERENCES BETWEEN WHITE AND NEGRO GROUPS.

SUBSCALE	White Group N=1096		Negro Group N=458		Clinical Sample N=50	
	Mean	S.D.	Mean	S.D.	Mean	S.D.
Pd 2	6.67	1.72	4.79	1.67	4.26	1.71
Pa 1	3.65	2.54	5.04	2.76	2.18	2.23
Sc 1A	3.32	2.85	4.75	3.06	3.66	3.34
Ma 4	2.86	1.62	3.94	1.78	2.38	1.70
	White-Negro		White-Clinical		Negro-Clinical	
	M/Diff	t-Ratio	M/Diff	t-Ratio	M/Diff	t-Ratio
Pd 2	1.88	28.27*	2.41	9.76*	.53	2.12
Pa 1	1.39	13.14*	1.47	4.55*	2.86	8.63*
Sc 1A	1.43	12.14*	.34	.71	1.09	2.24
Ma 4	1.08	15.93*	.48	1.96	1.56	6.25*

*Significant beyond the .01 level of confidence.

scores of the Negroes over both white and clinical samples on the Pa1, Sc1A and Ma4 subscales present a picture of lack of rapport with others characterized by withdrawal from meaningful social relationships, entertainment of persecutory ideas, projection of blame for difficulties and the overevaluation of one's own worth. The Negro responses to the Pa1, Sc1A and Ma4 indicate a greater predisposition toward psychotic traits than displayed by the white or clinical groups. The configuration of the Negro mean scores on these three subscales supports earlier findings at this institution which demonstrated that the mean MMPI profile of Negro inmates is more psychotic and less psychopathic in its configuration than the mean profile of white inmates.

Table 2 presents the comparison of the raw score means and standard deviations of the total inmate group and the clinical sample on the remaining subscales which produced significant mean differences beyond the .01 level of confidence. Inspection of the table reveals that the total inmate group scores significantly higher on subscales Pd4A, Pd4B and Ma1, and significantly lower (in the direction of greater normality) on subscales D1, D2, D4, Hy2, Hy3, Hy5, Sc2A, Sc2B

TABLE 2. COMPARISON OF MEANS AND STANDARD DEVIATIONS BETWEEN TOTAL INMATE GROUP AND CLINICAL SAMPLE ON MMPI SUBSCALES PRODUCING MEAN DIFFERENCES BEYOND THE .01 LEVEL OF CONFIDENCE.

SUBSCALE		Total Inmate Group N=1554		Clinical Sample N=50		M/Diff	t-Ratio
		Mean	S.D.	Mean	S.D.		
D	1	9.51	3.80	12.58	6.64	-3.07*	3.32
	2	5.72	1.76	7.60	2.25	-1.88	5.79
	4	3.16	2.15	4.84	4.02	-1.68	2.91
Hy	2	5.31	2.12	7.20	2.39	-1.89	5.47
	3	4.30	2.86	6.20	3.92	-1.90	3.36
	5	2.73	1.48	3.46	1.54	- .74	3.17
Pd	4A	7.68	2.64	5.84	3.07	1.84	4.15
	4B	7.36	2.54	5.30	3.75	2.06	3.82
Pa	3	3.29	2.11	5.18	2.24	-1.89	5.83
Sc	2A	1.71	1.82	2.88	2.70	-1.17	3.01
	2B	2.96	2.22	4.40	3.26	-1.44	3.07
Ma	1	2.52	1.51	1.84	1.55	.68	3.02
	2	3.82	1.49	4.84	2.22	-1.02	3.19

*(-) The total inmate group mean is in the direction of greater normality.

and Ma2. The subscales on which the total inmate group scored highest are those that imply feelings of isolation from other people, lack of gratification in social relationships, avowal of guilt, indifference concerning one's own motives and a callousness of feeling toward the conduct of others. The inmates appear less deviate than the clinical sample on those measures implying a negation of joy in doing things, immobilization, distrust of one's own psychological functioning, complaints about functioning below par physically and mentally, need for affection, inhibition of aggression, excessive generosity about the motives of others, the admission of autonomous thought processes, regression and hypoactivity. These results appear to indicate a lesser degree of neurotic and psychotic trends for the total inmate group and a greater degree of character dysfunction marked by an inability to establish warm interpersonal relations.

Summary

THE responses of 1,096 white and 458 Negro prison inmates to subscales derived from six of the MMPI clinical scales were compared with one another and with a clinical sample of fifty cases. The responses of the whites appeared more aggressively psychopathic than the responses of the Negroes or clinical sample, whereas the Negroes appeared more psychotic in their responses to measures of external influence, social withdrawal and ego inflation than either the white or clinical cases. On those subscales producing no racial differences the combined white and Negro groups appeared more deviant than the clinical sample on subscales appearing to measure personality dysfunction associatied with social and self-alienation. The responses of the total inmate group were closer to the normal than the clinical sample on measures of subjective depression, psychomotor retardation, mental dullness, need for affection and reinforcement, affirmation of moral virtue, lack of conative and cognitive ego mastery, and psychomotor acceleration. There were no significant mean differences appearing between the four groups (white, Negro, total inmate or clinical) on the D3, D5 Hy1, Pd1, Pd3, Pa2, Sc1B, Sc2C, Sc3, or Ma3 subscales.

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Aggression

John P. Scott, University of Chicago Press, Chicago

In 1939 a group of social scientists at the Institute of Human Relations at Yale pooled their ideas to bring some systematic order to a multitude of apparently diverse aggressive phenomena. Their book on *Frustration and Aggression* still stands as a model of interdisciplinary effort. Now, Dr. Scott, a renowned zoologist, deriving his insights from empirical and experimental studies of fighting behavior in animals, contributes the findings of physiology and ecology and re-emphasizes the significance of social forces in the etiology of aggressive behavior.

In the present frame of reference, aggression is equated with fighting behavior. As such it is primarily an adaptive response to such varied stimuli as pain, sex competition and territorial conflicts, and follows the principles of Pavlovian conditioning. Fighting behavior can be attached to secondary stimuli, generalized to similar stimuli and inhibited by the usual conditioning techniques. Moreover, aggression can become maladaptive when it does not bring the animal or subject closer to his original goal or is displaced to stimuli other than the original stimulus. When aggression is suppressed, it "tends to emerge in some less adaptive form." Indirect outlets, however, are necessary if we are to maintain mental health. It is the complete suppression of any or all outlets that leads to psychopathology.

The author questions the adequacy of the popular frustration-aggression theory to account for the arousal of an aggressive response. Aggression is not always a consequence of frustration. Animal experiments show that aggression can be taught when appropriately rewarded. Frustration leads to aggression only in those cases where the individual has a habit of fighting. This argument against frustration-aggression theory, however, is not completely valid. The "inadequacy" of the theory is due more to the author's failure to distinguish clearly (a) instrumental from reactive aggression and (b) the overt expression from the instigation to aggression. The lack of an aggressive response

following frustration does not necessarily indicate the absence of the aggressive drive.

The Freudian notion of the instinctual basis of aggression is examined and refuted by the physiological evidence presented by Dr. Scott. Analysis of the physiological changes accompanying fighting behavior in animals seems to indicate that, although there is some internal physiological mechanism, this has to be set in motion by some *outside* stimulus. Aggression is influenced by the nature of the social group of which the individual is a member and by such ecological factors as *changes* in the temperature, food supply and space restrictions.

Undoubtedly the book represents a worthy companion to the earlier volume on *Frustration and Aggression*. It brings fresh insights and a wealth of intriguing animal experiments, physiological and ecological data to bear on an admittedly complex problem. It is refreshing to see a zoologist acknowledge the contributions of the social sciences to a more complete understanding of aggression. The shortcomings of the book are characteristic of the attempts to bridge the gap between the animal world and the more complex human. The method of comparative analysis and inference serves to aggravate the problems of definition, interpretation and rationale of aggression. It would have been more appropriate perhaps to entitle the book Fighting Behavior in Animals. As it is, the present title of *Aggression* together with the introductory statement that the book deals with the causes, consequences and control of aggressive behavior in modern society is misleading and arouses expectations that are not fulfilled. It is difficult to see how the book can be, as the author believes, "useful to teachers and others who face practical problems of controlling aggression in their daily work." The few experiments cited in the human area are far from representative of the vast array of significant data now available. Notwithstanding, the present volume offers comprehensive perspective and an antidote to the general tendency to oversimplify the causative and control factors of aggression.

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Assessment of Human Motives

G. Lindzey, Editor, Rinehart & Co., New York

THIS very worth while book is well described as a variously succinct, variously clear, variously interesting set of reviews of books and papers by their own authors on the general topic of motivation. As such it is a useful guide book to the study of motives, motivational assessment and the place of the topic of motivation in personality theory as this study is being pursued by some of today's leading researchers.

The book developed from a set of lectures at Syracuse University, sparked by Editor Lindzey, sponsored by the Department of Psychology and financed by a grant from the U. S. Public Health Service. Lindzey has become concerned about the fuzzy conceptual status of motivation and had concluded that progress in the understanding of motivational problems can be best aided if "the terms that have been so effortlessly employed in theoretical discussion are given some reasonably precise means of empirical translation." Accordingly, eight psychologists were invited to address themselves to some or all of nine general questions relating to the assessment of motives (Example: At this time is the area of motivation more in need of developing precise and highly objective measures of known motives or identifying significant new motivational variables?).

The results are variously satisfying. The usual differences between spoken and tightly written argument are apparent in most of the articles. Some appear to have been considerably rewritten, others to have been taken directly from the tape recorder to the linotype. Readability, however, is generally good.

George Kelly presents an interesting, if somewhat polemical, review of his psychology of personal contructs, a prominent feature of which is the rejection of the concept of motivation in favor of a study of how and why people construct their alternatives for action. Leon Festinger presents in a paper of limited scope the book's only new research data in a clear discussion of the motivating effect of cognitive dissonance, affording the reader a good example of neo-Lewinian theory and research. George Klein's review of his work on cognitive control structures concludes with a recognition that "How structure

itself is to be conceived as an overriding issue," and invites attention to F. H. Allport's 1955 book as a lead to a possible solution. Klein states clearly the interesting paradox and achievement of personality: its allegiance to both drive aims and to environmental variation, and its relative autonomy from both. This similarity to Gordon Allport's writings is seen in Allport's discussion of "What units shall we employ?" in the study of motivation. We are treated again to Allport's eloquent case for the ideographic study of personality. In contrast stands R. B. Cattell's extensive exposition of the factor analytic approach to the testing of hypotheses of motivational organization and function.

Psychoanalytic views are quite differently represented by Roy Schafer and Irving Janis. Schafer discusses "regression in the service of the ego," with an interesting demonstration of the application of psychoanalytic theory in the interpretation of TAT, Rorschach and intelligence test protocols. Janis' chapter shows the way to improved use of the psychoanalytic interview in studying normal personality processes and gives us a most interesting discussion of obstacles to effective research by psychologists on psychoanalytic hypotheses. Among these is the requirement of the M.D. degree for membership in the American Psychoanalytic Association and the consequent discouragement of psychoanalytic training in clinical psychology curricula. Probably the least rewarding chapter is a discussion by H. A. Murray on "Drive, time, strategy, measurement and our way of life." The integration of this string of terms doesn't quite come off. There is, however, a small nugget at the end concerning how the Puritan ethic, "with its low evaluation of the art of life and its high evaluation of persistent effort for the sake of some ultimate reward," has operated to prevent a fuller study of creative action and other behaviors that carry their own intrinsic satisfactions.

It is unfortunate that the book completely lacks a behaviorist treatment of the motivation problem. Also generally lacking in most of the chapters is an effort to relate motivational concepts to the world outside the clinic; the extensive literature on motivation in military psychology is not represented.

On the whole, as an attempt to deal systematically with a restricted set of problems, this book is quite clearly a failure. Your reviewer hastens to add, however, that this particular failure is the book's greatest asset, and to express his satisfaction at having been

treated to so many convincing statements of quite different, occasionally opposing, points of view, and to have thereby been forced to defend — and revise — some notions he had begun to look upon as durable if not eternal truths.

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Family Relationships and Delinquent Behavior

F. Ivan Nye. John Wiley & Sons, Inc., New York

DR. NYE has followed the classical research pattern in which he identifies the problem to be studied, establishes the premise of his research and the method to be used. In addition, he pertinently contrasts his own thinking and findings with prior research in the topic under consideration.

The content is divided into three parts. Part one concerns itself with the theory and method used in the research; parts two and three respectively present results and interpretation of the results of the research undertaken, particularly as these concern family structure and delinquent behavior, and the parent-adolescent relationships in delinquent behavior.

Dr. Nye points out that "the problem of definition and measurement has long been a difficult one in delinquency research." He goes on to indicate that usually the problem is approached by using the institutional case as the criteria for identifying the delinquent. In his research Dr. Nye has made a departure from this pattern by attempting to evaluate delinquent behavior in a "non-institutional" and "non-official delinquent" segment of the population. The premise here is that many adolescents who have not come to the attention of community authorities nevertheless, upon close examination, might be considered to have committed delinquent acts. It is through a sampling of this "non-official delinquent" group that the author attempts to evaluate the causes of delinquency other than the ones usually considered valid by examination of the "official delinquent." Questionnaires and scales

of measurement were prepared. The questionnaire was answered by adolescents themselves. In this an attempt was made to secure material indicative of the interplay of attitude and relationships between the adolescent and the parent, from the point of view of the adolescent.

There is evaluation of many facets of family structure and family life differences such as socio-economic status, religious affiliation, sex differences, broken homes, employed mothers, discipline and punishment, recreation, etc. In general, the results of this research support the idea that "the identification with the parent by the child (indirect control) is associated with low delinquency" and that "delinquent behavior is at a minimum where there is a moderate amount of direct control exercised."

It is therefore implied that those individuals concerned with the prevention of delinquency should provide a supervised recreational program which can be implemented both by the school and by other community resources and that the internalized or indirect control of behavior can be advanced by improving the "parent-adolescent, teacher-adolescent, Minister-adolescent and police-adolescent relationships." Since the clinicians dealing with the psychiatric treatment of delinquents have for a long time emphasized the importance of these relationships, it may be comforting to have this study demonstrate and support the significance of this point of view.

It is often said that all "good" research merely points the way for further areas of needed exploration. This volume conforms to this standard by pointing out further needs for study of delinquent behavior. The current material has analyzed social control as exercised by the family, but it is considered equally important that significant control be exercised by the school, community authority figures, the church and peer groups and that these should also be analyzed within social control framework. In addition to suggesting the need for further study, Dr. Nye feels that his data sharply challenge previous assumptions concerning delinquency in relationship to the socio-economic status of the family group.

Perhaps the greatest contribution made by this study is that it points up the pitfalls those people working with delinquent adolescents may tend to fall into, namely, the danger of considering the delinquent to be a product of specific social or economic groups and the tendency to use as a control group in research only the "institutionalized" and/or officially known delinquents.

The conclusions and findings appear to substantiate concepts and theories often taken for granted by the clinicians, and this alone is a real contribution of the research study. However, to this reader at least, the volume is difficult reading since most of the narrative is couched in the language and terminology of the statistician, using codes and symbols that are not understood by the general population. Its reading audience, therefore, will of necessity tend to be limited.

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The Psychodynamics of Family Life

Nathan W. Ackerman, M.D., Basic Books, New York

THE mental health professions have long been concerned with the role of family environment in the development of personality. Despite this long standing clinical and therapeutic interest, active exploration into the potentialities of the total family as the therapeutic medium has only recently been initiated.

Until about the last decade, family diagnosis and psychotherapy have largely been a matter of individual diagnosis and individual psychotherapy with collaborative team effort used to approximate a comprehensive family approach. An exception to this trend and a pioneer in attempts to define concepts for the understanding of family interaction, Dr. Nathan Ackerman summarizes his experience in this book. This is not an exposition based on mere extension of individual therapy, modified only to deal with a group, but rather represents a position based on meaningfulness of family relationships as the proper therapeutic medium. It presents a conceptual approach to emotional disturbance in the individual through the analysis of the psychological content of his family experience."

Dr. Ackerman develops this presentation by first comparing psychoanalytic and individual treatment concepts with family oriented concepts. Through discussion of various clinical entities and case material, techniques for the diagnosis and treatment of family groups are outlined. The book ends with a good general overview and a section on broader implications.

It is this reviewer's opinion that techniques and theory for the therapeutic handling of total family experience represent a most significant advance in the mental health field. The development of such understanding will probably make psychotherapy available to a wider range of problems and a greater number of people than has heretofore been possible.

This book, one of the first and most comprehensive yet published, promises to play a major role in shaping and guiding the work of others in this area. It is a book to be considered "must reading" for student, teacher and practitioner. Not all readers will agree with all Dr. Ackerman outlines, few will disagree with everything, most will be stimulated.

The value of this book lies not only in the excellent presentation of a most difficult subject, but more importantly in the model the author offers for the dynamic understanding of the family, relating it outwardly to society and inwardly to the individual.

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THE NEW PSYCHIATRY

Nathan Masor, M.D., Philosophical Library, New York

DR. MASOR has treated a variety of psychiatric illnesses with thyroid substance and Vitamin B^{12}. At the end of his book, he presents fourteen case histories very briefly. The diagnoses include schizophrenia and several neurotic problems. The author claims excellent therapeutic results, and this treatment should be evaluated on that basis. However, this book is in no way a convincing presentation of a new clinical approach.

The author begins by attacking orthodox psychiatric methods in derisive and sarcastic terms. Psychonalysis and other methods of psychotherapy are denounced with equal vigor. The "orthodox psychiatrist" is described as follows: "Although his couch squeaks and cringes with agonizing cries of tormented souls, he is a most patient person, for he is content to wait months, years and perhaps decades before he can successfully alleviate his horizontal charge."

Dr. Masor then points out the impact of physiologic processes on mental functioning in some detail. He implies that orthodox psychiatry ignores these physiologic factors and only so-called "biological psychiatrists" apply them in their work.

The author then proceeds to describe his own method. He stumbled on this while experimenting with thyroid and Vitamin B^{12} for treatment of coronary atherosclerosis. An improvement in mood and behavior was observed and on the basis of this, Dr. Masor began using the drugs for many mental disorders. At no point are we given a rational basis for the therapy. No theory or experimental results are advanced to show how or why these substances affect human behavior. Certainly an attempt to destroy orthodox methods does not prove the worth of this method, which seems to be Dr. Masor's conclusion. Since his empirical use of thyroid and B^{12} may have some use, it deserves attention, assuming the clinical observation of patients was accurate.

Dr. Masor does not have to destroy the field of psychiatry to make a contribution to it. His manner of writing can only be offensive to a group of physicians who are as dedicated as he is, and who have had more experience in the study of human behavior.

RICHARD WELLMAN, M.D.

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The Challenge of Mental Illness

MENTAL illness, the greatest health problem in the world today, "fills more hospital beds than cancer, heart disease and tuberculosis combined," the United Nations Educational, Scientific and Cultural Organization asserts in a publication distributed throughout the world. And for every patient in a mental hospital, it adds, at least two others are living outside, neither ill enough to be hospitalized nor well enough to live a normal life. UNESCO estimates that nearly 2,000,000 persons in Europe and 600,000 in the United States are hospitalized with mental illness. There are no figures on the total amount of mental disorder in the world.

WORLD OF SOCIAL THERAPY

A miscellany of ideas, observations, comment and other signals of progress in the purview of the social sciences.

Abortions—A high majority of therapeutic abortions performed in hospitals in the United States are illegal under a strict interpretation of the law. Leading gynecologists conceded this when a New York hospital revealed that its criterion was the physical, emotional or mental health of the mother rather than the legal one of saving the mother's life. Of 147 abortions in one hospital in a five-year period, 39% were performed for psychiatric reasons, 31% to prevent birth of abnormal children, 10% because of a past or present cancer factor and 10% for other physical reasons.

Addiction—A syllogism presented by Dr. Benjamin Boshes of Northwestern University: Each narcotic addict costs the taxpayers $10,000 a year in crime losses, imprisonment costs, court and other expenses; Chicago's narcotics clinics cost $65,000 a year and in one of them alone twelve addicts were kept away from drugs for a year; therefore the clinics saved the state more than twice their cost.

Adoptions—Italy and Greece have started official investigations of alleged abuses in the "sale" of children by poor parents to adoptive parents in the United States seeking to circumvent normal legal procedures.

Amnesty—Italy, in one of its periodic amnesties, recently freed more than a third of the convicts in prisons and defendants awaiting trial. Such remissions are a traditional Italian device to reduce prison populations and clogged criminal court calendars.

Cancer—The American Cancer Society has launched a six-year statistical study, to be carried out by 50,000 volunteer workers who will question a million persons a year for data bearing on the theory that most cancers are caused by environmental factors — things that people come in contact with day by day.

Cities—While the Federal debt was increasing 2% between 1956 and 1958, the debts of cities increased 300%. While the Federal budget increased 13% to $77,000,000,000 in the last five years, city budgets rose 53% to $9,-200,000,000. Governor Edmund G. Brown of California presented these figures to the United States Conference of Mayors in Los Angeles. He said the settlement of each new family in a California city entailed a public capital outlay of $13,000 for schools, streets, sanitation and sewage. How long, he asked, would it take the city to get that back in taxes?

Crime—London's crime record reached a peak last year, Scotland Yard reports. Known indictable offenses totaled 151,756, a rise of more than 20% over 1957. Arrests of persons under 21 increased by about the same percentage.

Defamation—Following a Supreme Court ruling that Federal officials are immune from suit for defamatory statements, Attorney General Rogers cautioned all such officials to use extreme care in administering their "absolute privilege."

Diagnosis—Presumptive diagnoses of disease have been produced by electronic computers by feeding them data based upon earlier cases. Dr. Keeve Brodman, reporting on research at New York Hospital—Cornell University Medical College, found that the method was more effective in pinpointing somatic conditions than in those involving psychoneuroses.

Ducks—A study by psychologists at the University of Chicago of mallard ducklings in relationships with mature and decoy ducks indicated that five and a half to six months is a critical stage in humans' acquirement of social experiences determining adult behavior. The findings were reported by Dr. Eckhard H. Hess.

Prostitution—The United Nations is issuing a report of its Social Commission on *The Suppression of the Traffic in Persons and of the Exploitation of the Prostitution of Others*. Based upon the policy and principles embodied in the United Nations convention on the subject, the report takes note of recent changes in the norms of sexual behavior, patterns of prostitution and traffic in persons and the implications of such trends for the prevention of prostitution and venereal diseases.

Psychos—Army psychiatric cases requiring hospitalization have been at a record low point for two years. Service psychiatrists attribute the decline to preventive techniques developed in wartime, including mental hygiene units in training camps, rapid treatment and quick return to duty.

Retardation—Specialists at a recent international conference in Portland, Maine, generally agreed that mental retardation, which affects 3% of the world's population, is caused in large measure by oxygen deficiency in the infant at time of birth. An overplus of carbon dioxide in the interchange between mother and child is believed to upset the acid balance of the blood, resulting in brain damage.

Riot—A new twist in the epidemic of prison riots occurred when ninety-four convicts of the Brusky Mountain State Prison in Tennessee rebelled for thirty-two hours in the depths of a coal mine, holding three foremen as hostages. Fears that the men might use their dynamite supply in a violent gesture proved unfounded; they surrendered when officials granted some concessions.

Robberies—Bank robberies reached a record level in the year ended June 30, according to the F. B. I. The 764 violations of Federal law included 45 robberies, 233 burglaries and 86 larcenies. In the previous fiscal year there were 631 violations, compared with 606 in 1932, the height of the gangster era.

Smut—Postmaster General Summerfield received 70,000 complaints in the first half of this year against peddlers of pornographic pictures and literature, compared with 50,000 in 1958. There were 293 arrests last year, a 45% increase since 1954.

Teachers—To attract more talent to the teaching profession, Fordham University is offering full tuition grants to children of its faculty members. The plan also is regarded as an example to all colleges in the virtue of self-help.

Tension—Following a crowd flare-up in New York's Harlem district in which two policemen were hurt, Manhattan Borough President Hulan Jack warned that the people there were in an "angry mood" over inadequate housing, poor schools, insanitary conditions and low-paying jobs and that "the city's got to do something about it."

Vice—Britain has enacted a new street offenses bill sharply increasing penalties for repeated soliciting for purpose of prostitution. The measure is aimed at reducing the notoriety of vice traffic in London and other large cities.

Migration and Delinquency

WHILE the number of white children in Philadelphia was increasing 2.9% between 1930 and 1953, the number of nonwhite children increased 89%. Citing these figures to the Senate's subcommittee on delinquency, Municipal Judge Adrian Bonnelly said the migration of 500,000 persons from the South and Puerto Rico in less than thirty years was a key factor in the city's crime problem. "These so-called juvenile delinquents," he said, "are the offspring of unmarried mothers, putative fathers, unsanitary homes and lack of leadership among their own people."

AMONG THE AUTHORS

HARRY BRICK, M.D., took his medical degree at the University of Leipzig after graduating from City College, New York. After faculty work at the Medical College of Virginia, Richmond, he was wartime chief of psychiatric services in two general hospitals in the South Pacific. In addition to his psychiatric practice in Richmond, he is psychiatrist at the Virginia State Penitentiary and consultant at several other institutions.

WILLIAM H. DOUB JR., M.A., received his B.S. degree in chemistry at Richmond College and his M.A. in psychology at the University of Richmond's Graduate School. A former consultant with the Children's Bureau, he has been psychologist at the Virginia State Penitentiary for eight years.

WILLIAM CARROLL PERDUE, B.S., received his degree in sociology and criminology at the Richmond Professional Institute of the College of William and Mary. After graduate work in clinical and applied psychology, he entered the State of Virginia's correctional service in the field of inmate classification.

JOHN D. ARMSTRONG, M.D., is Medical Director of Treatment Services of the Alcoholism Research Foundation of Ontario. A graduate of the University of Toronto, he was an officer in the Royal Canadian Army Medical Corps during the war. He has been associated with Sunnybrook Hospital, Toronto, and has taught clinical psychiatry at the University of Toronto, in addition to his work with the foundation and in private practice.

JAMES LINCOLN McCARTNEY, M.D., and JAMES ROBERT McCARTNEY, M.D., comprise a father-son team that is becoming as well known jointly as the parental member long has been individually. Dr. J. L. practices neuropsychiatry in Garden City, N. Y., and serves as consultant to the Nassau County courts. A graduate of the University of Chicago and Rush Medical College, his career has included residency in St. Elizabeths Hospital, private practice in China, a fellowship at the New York Institute for Child Guidance and terms as State Director of Mental Hygiene for Connecticut and Director of Classification in the New York State Department of Correction. Commissioned in the Navy Reserve since 1926, he was on active duty in World War II. A textbook on classification of prisoners, written under a Salmon Memorial Committee grant, is one of the many books he has produced in addition to some 600 articles. Dr. J. R., representing the fifth generation of medical men, after graduation from Columbia, interned at Boston City Hospital and spent two years in the Army, in charge of the mental hygiene clinic at Fort Campbell. Following a residency at St. Elizabeths, he is now at the Institute of Living in Hartford. In 1961 father and son will be practicing together.

ALEXANDER B. SMITH, Ph.D., also holds the degrees of A.B., M.A. (Education), LL.B. and M.A. (Sociology). He is case supervisor in charge of the Group Therapy Unit of the Kings County Court Probation Department, Brooklyn. He is lecturer in criminology at Brooklyn College and group therapist at the BARO Civic Center Clinic. He is a New York State Certified Psychologist.

ALEXANDER BASSIN, Ph.D., won that degree at New York University Graduate School of Arts and Science with a dissertation involving an experimental evaluation of the effectiveness of group therapy. He is in charge of the Psychological Testing Service at the Kings County Court Probation Department and is Director of Group Therapy at the BARO Clinic. He also is Adjunct Professor at Yeshiva University Graduate School of Education and, like Dr. Smith, is a New York State Certified Psychologist.